The Journal of the American Medical Association

Published Under the Auspices of the Board of Trustees

VOL. 124, NO. 18 — CHICAGO, ILLINOIS — APRIL 29, 1944

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FATAL CORONARY ARTERIOSCLEROSIS IN YOUNG SOLDIERS

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Since the beginning of the present war the Army Medical Museum has received protocols and tissues from more than 100 fatal cases of coronary arterial disease in soldiers 20 to 36 years of age. The chief facts concerning 80 such cases in which deaths seemed due to uncomplicated coronary lesions form the basis of this report.

PREDISPOSING FACTORS

(*a*) *Racial.*—Three of the men were of Negro and 2 of American Indian ancestry. None had names usual among Jews of European stock, and few appear to have been of Jewish faith or ancestry. Most common were names of Irish or English origin, but there were also Italian, French and Slavic names. In brief, no racial tendency toward coronary sclerosis was indicated in the present series.

(*b*) *Constitutional Factors.*—There was a tendency to obesity. Eleven men were "very obese," 29 were "obese" and 33 were above "ideal weight for height." In summary, 73 of 80 young men who succumbed to coronary disease were over weight. Only 2 were "thin."

(*c*) *Tobacco.*—Histories of the use of tobacco are not recorded regularly, but it was not stated that any of these men were nonsmokers. This is not significant in view of the almost universal use of cigarets among our armed forces.

Age Distribution.—The accompanying table gives the age distribution in the present series. As the number of soldiers in each group probably falls off after the age of 25, the incidence of fatal coronary disease per thousand soldiers undoubtedly rises more rapidly than the case numbers of the table would indicate. Fatal coronary disease obviously is far more frequent at 36 than at 20. Only after the war has ended will it be possible to give the case rate for clinically recognized coronary disease, and the annual fatality rate per thousand soldiers. It should be emphasized, however, that only 6 of the 39 men whose hearts showed old areas of fibrosis had reported any complaint prior to the fatal attack; hence it is probable that the actual incidence of coronary disease in the age group under analysis is much more frequent than is suggested by clinically recognizable and fatal cases.

Prodromes.—Fifteen soldiers commented on chest pains to their associates a few days or weeks before the final episode but did not report for sick call. Such comments probably escaped recording in many cases; in fact, pain which was experienced may not have been complained of to any one. Ten soldiers had reported chest pains at sick call; often it was trivial, but in several cases coronary disease was "ruled out" by careful study. Two of these soldiers had pain regularly related to meals and relieved by belching. In addition to the 10 soldiers with chest pain 1 reported dyspnea; careful clinical study failed, however, to disclose evidence of coronary disease. Three other patients had had palpitation; of these, auricular tachycardia was proved in 1, numerous "ectopic beats persisting during exercise" in another; the third had no demonstrable arrhythmia. Death occurred many weeks after these reports, and the 3 men had carried on full duty with no further complaint. In summary, in over one third of the group there were prodromal symptoms suggestive of heart disease.

Factors Precipitating the Final Episode.—Febrile illnesses were noted only twice. Both were mild upper respiratory infections treated with rest and adequate care and terminating four and ten days prior to the attack. Trauma to the chest was noted in only 1: a nondisabling bump incurred while playing football two months previously.

One case of sudden death, one fatal three hour seizure and one sudden death of a soldier hospitalized for a study of angina of effort occurred while these men were at stool. They had no pain when they went to the latrines. "Bearing down" with a closed glottis (Valsalva experiment) is notoriously dangerous for cardiac patients.

In 8 cases there were no data on physical activity just prior to the final attack. In 28 instances the history indicates nothing out of the routine of a day in which walking is the only sustained exercise. Marching with a pack is considered as "vigorous exercise," and it is remarkable, in view of the soldier's chances for vigorous activity on or off duty, that about 40 per cent of these men had not had such exercise within a day or so of their final cardiac break.

In 15 cases sudden death or the onset of severe pain in a fatal seizure occurred during vigorous or violent muscular effort. Twenty-six patients, or 35 per cent, had the fatal attack within one to several hours after "vigorous exercise"; 5 of these "dropped dead" and 4 died in sleep, as did 3 who had not been unusually active.

From the Army Medical Museum, Institute of Pathology, and the Department of Pathology, Cornell Medical College.

Mode of Death.—Of the 80 patients in this series 39 died suddenly, losing consciousness without complaint of any kind; 7 died in sleep and another awoke with pain and died shortly thereafter. Twenty-four soldiers had a painful seizure of a few minutes duration; 11 of these died suddenly and the rest passed quickly into shock, cyanosis or pulmonary edema.

Six patients lived for several hours, 3 others for a day or two after the onset of pain. One man manifested intractable congestive failure, with death six weeks after the onset of dyspnea. Another soldier developed a fatal hemiplegia during drill and died four days later. He had a well healed massive infarct with extensive mural thrombosis and had been doing full duty unaware of a lesion weeks old, which had developed into an aneurysm. One man had one day of typical pain, five days of fever and an uneventful six weeks of rest in bed. He died in bed during the eighth week, after sitting up a few hours daily for nearly a week; no pulmonary embolus or fresh thrombus was found to explain the sudden terminal collapse.

Age Distribution in the Cases of Fatal Coronary Disease in Soldiers Aged 20 to 36

Ages in years	20-22	23-25	26-28	29-31	32-34	35-36*
Number of cases	5	9	11	14	21	20

*Note that age distribution is given in three year periods, except in the last column.

These histories indicate that while vigorous effort may precipitate the final break in young men with coronary occlusion, complete or partial, neither sedentary life nor bed rest, nor even sleep itself completely protects the heart from a fatal outcome. The frequency with which the attack occurs in the early morning is striking. A typical instance is the man who fainted while shaving, recovered, ate breakfast and then had a painful seizure, fatal within the hour. Only 10 per cent of the fatalities occurred during sleep. In 17 per cent of the series the attack began during the first two hours of the morning and before drill. The sudden change from complete rest to the effort of dressing and starting a new day may possibly be a special hazard.

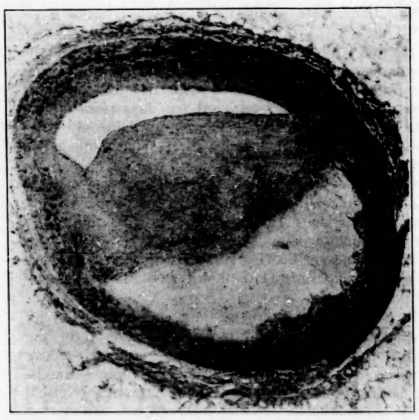

Fig. 1.—A soldier aged 22 dropped dead while marching in review. The heart weighed 280 Gm. and did not show any infarct or scar. The descending branch of the left coronary artery was stenosed, the circumflex branch and the right coronary were narrowed by yellow plaques. There were plaques in the anterior mitral leaflet and in the root of the aorta. The section shows a large plaque with the media largely intact and relatively acellular fibrous tissue over the "lake" of hyaline and fatty debris. Reduced from a photomicrograph with a magnification of 60 diameters.

Fig. 2.—A soldier aged 21 died suddenly while marching double time on the drill field. The heart was not enlarged. The intima of the root of the aorta showed atheroma, as did both coronary arteries. The abdominal aorta was not involved. The section shows an area of the left descending coronary artery. Calcification and cholesterin slits are prominent. Note the replacement of the media by fibrous tissue. Reduced from a photomicrograph with a magnification of 50 diameters.

Pathologic Anatomy.—In 57 cases the heart weights were recorded; the average was 365 Gm., with three fourths of the weights falling between 300 and 440 Gm. The hearts of 35 control subjects (deaths from automobile accidents, same age group) averaged 339 Gm., with three fourths falling between 275 and 395 Gm. The victims of accidents were not as overnourished as those of the coronary group; the figures therefore show that the soldiers' hearts are somewhat heavier than those of the average person and also that coronary disease causes no significant hypertrophy in the hearts of young men. This is in accordance with the data of others [1] but not with those of some observers.[2]

Recent infarction was demonstrated in 15 cases, and fibrous scars, with or without fresh necrosis, were noted in 39. Such lesions generally increase heart weight; moreover, hypertension cannot be excluded in all the cases. Nevertheless the rarity of hypertrophy in these 80 men with inadequate coronary flow does not support the idea that an inadequate blood supply to the myocardium is a factor in inducing cardiac hypertrophy.

1. Miller, H. R., and Weiss, M. M.: Disease of Coronary Arteries: Its Occurrence Without Gross Cardiac Hypertrophy, Arch. Int. Med. **42**: 74 (July) 1928. Maun, M. E.: Influence of Coronary Sclerosis, Chronic Congestive Heart Failure, and Myocardial Fibrosis on Cardiac Hypertrophy, J. Lab. & Clin. Med. **26**: 1239, 1941.

2. Katz, L. N.; Sanders, A.; Megibow, R. S., and Carlen, S.: Heart Size and Experimental Atheromatosis in the Rabbit, Am. J. M. Sc. **200**: 731, 1940. Shobet, A. S.; Taub, S. J., and Kupersmith, H.: Studies Concerning Relationship of Coronary Sclerosis to Heart Weight and Right and Left Ventricular Hypertrophy, Illinois M. J. **77**: 240, 1940.

The coronary lesion present in every case was arteriosclerosis. Lesions were present in more than one coronary artery in 67 cases. What was apparently the most important stenosing lesion involved the main or the descending branch of the left coronary artery in 63 cases, the right in 11, the circumflex branch of the left in 6. This left sided preponderance is well known.[3] In 35 instances only 1 coronary artery was narrowed, but significant narrowing was found in 2 of the 3 large branches—left descending, left circumflex, or right—in 17 cases, and in all 3 of them in 28 others. Thrombosis was proved in 29 cases. Aortic plaques or streaks were noted in 61 cases. Significant disease of the arterioles in the viscera was found in none of these cases.

Seventy-five patients had typical lipid and hyaline coronary plaques (fig. 1). In 5 patients the plaques were richly cellular, with many fat-filled macrophages; they resemble xanthoma without giant cells (fig. 3) and are of the type sometimes thought to develop rapidly. Hemorrhages in plaques were seen in only 5 cases, in none of which was there evidence of a preexisting arteritis. In 30 of these cases calcific deposits were noted. Lesions resembling periarteritis or thromboangiitis were present neither in the heart nor elsewhere in any case in the series.

The media and the inner elastic membrane usually appeared normal under the smaller plaques, and not infrequently under very large and fatal lesions (figs. 1 and 3). This was especially the case when the plaques were cellular and avascular. The older and the well vascularized atheromas often covered a region of medial atrophy or even complete fibrous replacement of muscular elements. This was seen only at the center of the plaques, for the media was intact at the edge (fig. 2). Lymphocytic infiltration and fibrous thickening of the adventitia and of other layers were seen most often in older men. In a few of the younger patients such changes were associated with calcification (fig. 2), extensive vascularization of the plaques or medial atrophy. These facts are interpreted as indicating that the plaques precede the medial lesion.

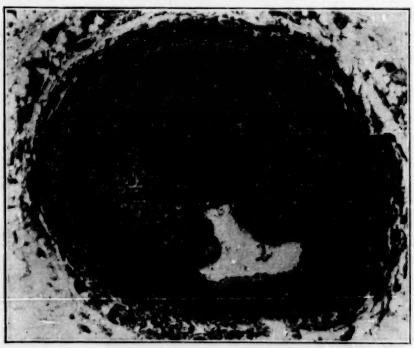

Fig. 3.—Just after supper a soldier aged 21 was seized with pain in the precordium and died suddenly. The heart weighed 415 Gm. and had a scar at the base of the left ventricle. There were small plaques at the base of the aorta, and a large plaque (shown in the section), richly cellular and containing many "foam cells," in the descending branch of the left coronary. The media was intact. Reduced from a photomicrograph with a magnification of 70 diameters.

3. Maxwell, E. S.: Pathology of Coronary Disease, Kentucky M. J. 41:79, 1943.

CASE HISTORIES

Case Illustrating Absence of Symptoms with a Large Infarct.—A staff sergeant aged 24 had a complete physical examination on October 16. The pulse rate returned quickly to normal after exercise, and no abnormality was noted. He had no complaints then or later, ate well and carried out his duties, drill and off duty activities until November 6, when he had a "spell" after calisthenics, became stuporous and had right hemiplegia and a blood pressure of 135/75. On the fourth day his temperature rose to 109 F. before death.

A large mural thrombus was found in the left ventricle, and an embolus was present in the right internal carotid. The descending branch of the left coronary was thrombosed, and there was a large infarct of the anterior and septal wall of the left ventricle, which showed definite fibroblastic replacement of the necrotic tissue and thinning of the wall.

Case Illustrating Death After Exercise and Cold Drink.—An artilleryman aged 28 participated in a battle indoctrination course on the desert about May 1 in the afternoon. He seemed well up to the time he took "a cold drink" before supper. Almost immediately he had a "spell" and died after a few gasps.

There was pronounced narrowing of the descending branch of the left coronary and some narrowing of the right by arteriosclerosis but no infarct or scar in the heart.

Cases Illustrating Death During Violent Effort.—A cavalryman aged 33 never had had any physical complaints. As he finished the obstacle course, not for the first time, he said "Gee, that one got me!" and fell dead. All three main coronary branches were narrow, the descending almost closed by arteriosclerotic plaque. The left ventricle had many small silvery white scars close to the endocardium; the heart weighed 308 Gm.

While hauling ashore a large net one of a group of men became exhausted, and a staff sergeant aged 25 swam over, rescued him and dropped dead. The descending branch of the left coronary artery was "almost obliterated by an atheromatous plaque." There were no scars in the heart, which weighed 310 Gm.

An artillery man aged 32 crawled 50 yards on his abdomen on the infiltration course; he then complained of exhaustion and slight precordial pain. He refused to be carried to the dispensary ¼ mile away but had severe pain radiating from the chest to the left hand on arrival. His pulse rate was 45; he was gray but not dyspneic. He died in a few minutes. There was narrowing of all 3 main coronary branches, almost complete occlusion of the descending branch of the left; the 315 gram heart showed no scars.

Cases Illustrating Unusual Prodromal Features.—A Negro soldier aged 35 complained of attacks of "fast heart beat," weakness and "staggers." These occurred in the morning for nearly six months before he was kept under observation for twelve days in the station hospital. All studies were negative, chest x-ray examinations normal, electrocardiograms not available. The pulse ranged from 60 to 115, without arrhythmia. The discharge diagnosis was neurocirculatory asthenia. Twelve days later he dropped dead during drill. The heart was not remarkable save for almost complete closure of the descending branch of the left coronary.

A corporal aged 23 was seen in the dispensary from February 23 to March 4 for indigestion and was then hospitalized for nine days. Just after meals he had a dull ache in the upper abdomen, frequently associated with vomiting. He was flatulent, suffered from constipation, had a poor appetite and was losing weight. All tests, including gastric x-ray films and test meal, were normal. The diagnosis was neurasthenia. By March 24 he had lost 15 pounds (7 Kg.) and had the same complaints;

the sedimentation rate and chest x-ray film were normal. He had no difficulty with work or drill but died suddenly while dressing on April 4. The left descending branch was practically closed at its origin by an internal plaque. The muscle showed slight interstitial fibrosis. There was no lesion of the stomach, intestine or gallbladder.

Fig. 4.—Section of a coronary artery with a lateral branch. In the main vessel the intima is evenly thickened throughout the entire circumference, but with no atheroma. Note by contrast the delicate intima of the branch artery. Reduced from a photomicrograph with a magnification of 435 diameters.

COMMENT

Clinical.—That arteriosclerosis of the coronary arteries occurs in young adults, or even before adolescence, is well known,[4] as is the frequent occurrence of such lesions in young persons with familial xanthomatosis.[5] But under the conditions of military life, with its lack of privacy and frequent access to medical examiners and physicians, it is possible to learn more about the story of fatal cases than is true in civil life. In many of these, had death occurred during or after dances, games or other strenuous civilian pursuits, there would have been a coroner's inquest, few would have been closely observed and reported and in many there might not have been an autopsy. The present report is intended only to round out the story of the clinical features of coronary disease which will eventually be told by physicians with the armed forces. At that time the facts here reported can be of value in calculating the total incidence of recognized and of fatal cases. Only 1 in 8 of the patients who died survived for an hour or more after the final episode began. Less than half of those who mentioned prodromal symptoms sought professional advice, and only 1 of the 14 whose symptoms might have remotely suggested this condition had received a correct diagnosis and been treated before the fatal attack. Of the 39 with scars in the heart muscle, only 6 had reported at sick call for symptoms which in retrospect may be regarded as cardiac. It seems safe to conclude that in this age group undiagnosed and undiagnosable organic disease due to coronary arteriosclerosis is much more frequent than is recognized.

We know the circumstances at the onset of the 64 of the 72 fatal attacks which began during the day, and we know that 7 men died in sleep and 1 awoke with pain at the onset of his fatal seizure. Using these data, and assuming that soldiers in training or noncombatant duty sleep eight hours and have two hours of vigorous activity and fourteen hours of activity like that of many civilians, we have calculated the risk of onset of fatal seizures at various levels of activity during the "average day" of such a group of young soldiers. Taking 1 onset per hour during sleep as the base line, since 8 actually occurred, the incidence calculated is 10 per hour during vigorous effort, 7 per hour during the first two hours after awakening and 3 per hour during the rest of the day's activity at the "nonvigorous" level. The average for the fourteen hours of normal activity is 4 per hour, as compared with 1 onset per hour during sleep. It must be emphasized that this refers to activity when the final episode begins and does not shed light on any possible relationship of activity or effort to formation of sclerotic plaques or the occlusion of the arteries by a thrombus or spasm. Presumably activity does increase the risk of hemorrhage into the plaques.[6] It is obvious that in many of these cases occlusion, infarction or severe scarring of the heart was present days before the fatal disorder was dramatically revealed. We are here concerned with the effect of sleep and of various levels of activity in precipitating the final episode, and there can be little doubt that, while vigorous effort and even the starting of a new day's activity are far more hazardous than sleep, young men with coronary disease run only a moderate risk of having their disorder become manifest during ordinary activities of camp life.

Pathologic.—Death without scar or infarction and death with only a single occlusive lesion is perhaps more frequent in young men than in older ones dying of this disease. While all of the classic pathologic features of arteriosclerosis are seen in even the youngest fatal case, solid cellular xanthomatous plaques are somewhat more frequent in the younger group. This study adds nothing to our knowledge of the etiology of atheromas

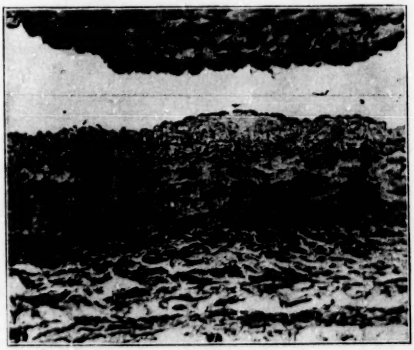

Fig. 5.—A soldier aged 19 was killed in an automobile crash. No lesion of the heart or coronary arteries was found. The section shows opposite sides of a coronary artery (the lumen of which has been reduced). The thickness of the intima is minimal for vessels of the age group under discussion. This normal artery is included as a "control." Reduced from a photomicrograph with a magnification of 150 diameters.

4. Master, A. M.; Dack, S., and Jaffe, H. L.: Age, Sex and Hypertension in Myocardial Infarction Due to Coronary Occlusion, Arch. Int. Med. **64**: 767 (Oct.) 1939. Glendy, R. E.; Levine, S. A., and White, P. D.: Coronary Disease in Youth, J. A. M. A. **109**: 1775 (Nov. 27) 1937.

5. Engleberg, H., and Newman, B. A.: Xanthomatosis: A Cause of Coronary Artery Disease in Young Adults, J. A. M. A. **122**: 1167 (Aug. 21) 1943. Müller, C.: Xanthomata, Hypercholesterinemia, Angina Pectoris, Acta med. Scandinav., 1938, supp. 89, p. 75.

6. Nelson, M. G.: Intimal Coronary Artery Hemorrhage as a Factor in the Causation of Coronary Occlusion, J. Path. & Bact. **53**: 105, 1941.

or the predilection of these lesions for the epicardial branches of the coronary artery. Involvement of the thoracic aorta with absence of plaques in the abdominal aorta seems more frequent in the young. Colonel Lucké [7] noted this in autopsies on soldiers in 1918.

The coronary vessels which were not involved in any atheromatous process often had remarkably thick intimal layers. This was striking when epicardial branches of the coronary arteries of men killed in accidents (fig. 5) were compared with some of the normal arteries (fig. 4) of those who died of coronary occlusion, or those whose coronary arteriosclerosis was merely an incidental finding. While it is well known that the epicardial coronary arteries in infants, children and adults have intima far thicker than any other arteries of the same size in the body,[8] the individual variation of this tissue, and the relation of such variations to atheromatosis, is not known. Leary [9] regarded the thick intima as evidence of local stress in the artery. The succulent tissue found in many coronary arteries seems to offer a better soil for the deposition of plasma lipids [10] than does the extremely delicate intima of the splanchnic, carotid and other medium sized or large sized arteries. That the lipids in the atheroma come from the plasma seems to have been proved beyond any doubt.[11]

The medial changes seem to us to be secondary and frequently related to vascularization of the plaque as well as to atrophy from disuse. A lymphocytic response is more evident in those over 30 and is presumably a nonspecific reaction similar to that in arteriosclerotic kidneys or in the breasts, thyroids and adrenals of older subjects.

SUMMARY

1. An analysis of the clinical and pathologic features of 80 fatal cases of coronary disease in soldiers aged from 20 to 36 revealed that the disease occurred in men of various racial and national origins, showing no predilection for any particular stock.

2. The most striking presumable predisposing factor was overweight, which was present in 91 per cent of the cases.

3. Vigorous effort, and the activities of early morning chores, brought on the fatal attacks in over 50 per cent of the cases.

4. Sudden death, or the onset of the fatal attack, occurred during sleep in 10 per cent of the cases.

5. The basis of coronary occlusion was found to be arteriosclerosis in all cases. Arteriosclerotic plaques in more than one coronary branch were found to be present in 84 per cent. Definite thrombosis was proved in 36 per cent of the series.

6. Myocardial scars, indicative of previous insults, were observed in 59 per cent of the cases. Recent myocardial infarction was noted in 19 per cent.

7. Cardiac hypertrophy of significant degree did not occur in this series.

7. Lucké, B.: Personal communication to the authors.

8. Spaltholz, W., and Hochrein, M.: Untersuchungen am Koronarsystem: Die anatomische und funktionelle Beschaffenheit der Koronararterienwand, Arch. f. exper. Path. u. Pharmakol. **163**: 333, 1932.

9. Leary, T.: The Pathology of Coronary Sclerosis, Am. Heart J. **10**: 328, 1935.

10. Leary, T.: The Genesis of Atherosclerosis, Arch. Path. **32**: 507 (Oct.) 1941.

11. Hirsch, E. F., and Weinhouse, S.: The Role of the Lipids in Atherosclerosis, Physiol. Rev. **23**: 185, 1943.

THE USE OF NEOSTIGMINE IN THE TREATMENT OF MUSCLE SPASM

IN RHEUMATOID ARTHRITIS AND ASSOCIATED CONDITIONS

PRELIMINARY REPORT

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Rheumatoid arthritis shows certain signs which bear close resemblance to those of anterior poliomyelitis. Outstanding among these are muscle spasm and atrophy. Such muscle spasm persists even though the arthritic process has become quiescent, and results in limitation of motion, deformities, weakness, fatigue and pain on pressure or stretching of the affected part.

In poliomyelitis the so-called muscle spasm has been treated with apparent success by the use of hot fomentations in accord with the Kenny technic.[1] In subacute and chronic poliomyelitis, neostigmine (prostigmine) has been used with encouraging results by Kabat and Knapp.[2] Our purpose in this study was to apply the principles set forth by the latter investigators to the muscle spasm accompanying rheumatoid arthritis and similarly related conditions.

Rheumatoid arthritis is generally thought of as a condition which affects primarily the joints, resulting in a destructive lesion affecting the motion of those joints. However, we are of the opinion that, even though the disease process in the joint has become quiescent, there remains a spastic state of the muscles surrounding that joint. This spasm involves both flexor and extensor muscles and is manifested clinically in various types of painful deformities. Obviously, if this hypothesis is true the relief of such spasm would result in much increased comfort of the patient and a consequent diminution or even complete prevention of deformities.

We have employed neostigmine in relieving such spasm in accordance with the concept promulgated by Kabat and Knapp.[2] The latter believe that neostigmine has a direct action on the spinal cord which may be depressing in nature in some instances and stimulating in others, depending on the groups of neurons which are acted on. In cases of rheumatoid arthritis we believe the action is probably depressive, as the muscle spasm is usually promptly alleviated.

CLINICAL MATERIAL

The entire preliminary group consisted of 19 patients, all of whom had rheumatoid arthritis or similarly related conditions. Each patient had been observed for several months prior to neostigmine therapy so as to gain an accurate impression of their clinical status and of any progress which they might be making. Patients selected exhibited a maximum of deformity and definite loss of function and limitation of motion but a minimum of active joint involvement. Many had received previous courses of gold salt therapy.

From the Arthritis Clinics of the Philadelphia General and Jefferson hospitals.

The prostigmine methylsulfate and prostigmine bromide used in this study were supplied by Hoffmann-La Roche, Inc., Nutley, N. J.

1. Pohl, J. F., and Kenny, E.: The Kenny Concept of Infantile Paralysis, St. Paul, Bruce Publishing Company, 1943.

2. Kabat, H., and Knapp, M. D.: The Use of Prostigmine in the Treatment of Poliomyelitis, J. A. M. A. **122**: 989 (Aug. 7) 1943.

TECHNIC

Before neostigmine treatment was initiated, each patient was given a careful physical examination with especial reference to the amount and degree of deformities of various joints. Actual angle measurements were usually made and recorded before and during the period of treatment. An estimate of the ability to perform certain common movements, such as arising from a recumbent position, sitting, turning, washing the face and feeding, was made in each case.

Treatment was generally started by the subcutaneous administration of 1 cc. of neostigmine methylsulfate 1:2,000 (0.5 mg.) and 0.6 mg. of atropine sulfate given every other day. Seven and five-tenths to 45 mg. of neostigmine bromide, usually with 0.6 to 1.2 cc. of tincture of belladonna, was given daily in most cases. It is to be noted that the only purpose of the atropine and/or belladonna was to forestall any possible undesired effects of neostigmine on the myoneural junctions of the parasympathetic nervous system. Careful observations were made on the immediate effect of the neostigmine as well as on the general progress of the patient.

REPORT OF CASES

Case 1.—E. G., a white woman aged 62, was observed to have rheumatoid arthritis involving the right hip joint, legs, feet and hands. She was given 1 cc. of neostigmine methylsulfate 1:2,000 and 0.6 mg. of atropine sulfate subcutaneously and within a few minutes slightly easier movements of the fingers were observed. She was able to lift her pocketbook with her right hand, a previously impossible act. It was decided to give her a maintenance dose of one 15 mg. neostigmine bromide tablet orally three times a day. When seen forty-eight hours later the patient was able to dig the fingernails into the palms and make a fist. Arising from a recumbent position in bed was now performed without aid. Whereas before neostigmine therapy she could but splash water in her face to wash, she was now able to perform this act with comparative ease.

One week after initiation of therapy she reported that despite 45 mg. of neostigmine bromide daily she was beginning to "get stiff again." Two cc. of neostigmine methylsulfate 1:2,000 with 0.6 mg. of atropine sulfate was accordingly given subcutaneously, the effect of which was not manifest for about four to five hours and lasted forty-eight hours. At this time the parenteral dose was repeated with prompt alleviation of symptoms. Therefore, for the next five weeks 2 cc. of neostigmine methylsulfate with 0.6 mg. of atropine sulfate was given every second day in addition to 15 mg. of neostigmine bromide three times daily by mouth.

At present the patient has received neostigmine therapy for approximately ten weeks. Improvement is slow but continuous, and we intend to continue with this treatment until such time as no improvement is manifest, following which a maintenance dose of neostigmine will be established.

Case 2.—O. K., a Negro woman aged 63, had been bedridden for one year because of rheumatoid arthritis and had been hospitalized for about six months prior to the institution of neostigmine therapy. The patient had a complicating diabetes mellitus which was considered irrelevant.

When first seen she was confined to her bed, was unable to feed or otherwise care for herself and was for all practical purposes a complete invalid. The arthritic lesions included a pronounced flexion deformity of the knees and feet, a rigid spine and "claw hands." Motion in almost any joint was limited and very painful. Goniometric measurement of the right knee showed 90 degrees flexion in the immobile position, with shortened hamstring tendons. The left knee was flexed to 110 degrees with a similar status of the hamstring muscle group. In general, the patient assumed a modified fixed fetal position. Previous therapy consisted in salicylates and gold salts but was of no value.

A test dose of 2 cc. of neostigmine methylsulfate 1:2,000 with 0.6 mg. of atropine sulfate was given subcutaneously. Within fifteen minutes the right knee extended to 130 degrees and the patient was able to cross the right knee over the left. The improvement was maintained for five days without additional therapy. Subsequently a similar dose of neostigmine methylsulfate and atropine was given every two days. One month after initiation of this treatment the medication was changed to two orally administered neostigmine bromide tablets with 0.6 cc. of tincture of belladonna three times daily.

As the therapy was continued, the patient was observed to have more and more improvement. She was able to open and close her hands, get out of bed and into a wheelchair without assistance, wash her hands and face and comb her hair, and could place her hands and arms in back of her head. After three months of neostigmine therapy the limit of improvement was reached, a state which was occasioned by the partial bony ankylosis of many joints. It is of particular interest that all previous therapy had been given to no avail.

Case 3.—R. B., a white man aged 42, complained of pain in the right shoulder of three weeks' duration. The pain radiated to the right lateral aspect of the neck. Abduction of the arm or rotation of the head was impossible without excruciating pain.

Previous therapy consisted of baking and massage, procaine infiltration about the cervical vertebrae, removal of several diseased teeth and analgesics. Relief was temporary with the procaine injections; otherwise the patient was in constant pain.

Examination revealed several points of tenderness in the right scapular region. Right shoulder movement was limited in all directions. A roentgenogram was reported as revealing "hypertrophic arthritis involving all the cervical vertebrae as evidenced by thickening and sclerosis of articulating surfaces, narrowing of the intervertebral spaces and foramina. There are some arthritic changes in the right acromioclavicular articulation."

Treatment was instituted by administering 2 cc. of neostigmine methylsulfate 1:2,000 with 0.4 mg. of atropine sulfate subcutaneously every four to six days. In addition, 7.5 mg. of neostigmine bromide and 0.3 cc. of tincture of belladonna were given by mouth three times daily. Relief was experienced within a few minutes after the initial injection of neostigmine. Voluntary movement was definitely greater in the cervical spine, and pain was but slight. The patient has now been receiving neostigmine for several months, a procedure which has kept him relatively free from pain.

Case 4.—A. B., a white man aged 52, gave a history of the sudden onset of sharp, lancinating pain in the lumbar area while arising from bed. Relief in some degree was obtained by sitting or lying down. After he had walked a few steps the pain lessened and was reduced to a soreness. There was no radiation to any other area.

The patient was well built and well nourished. The lumbar muscles exhibited some rigidity bilaterally. Flexion of the lumbar spine was limited to a 150 degree angle, and there was some limitation of lateral motion.

Ethyl chloride spray to the lumber area gave some measure of relief by partially relaxing the muscle spasm. The relief persisted for but two hours, following which the pain was as severe as at the onset. Accordingly 2 cc. of neostigmine methylsulfate 1:2,000 with 0.6 mg. of atropine sulfate was given subcutaneously. Within fifteen minutes the patient stated that he was greatly improved. Flexion of the trunk was now possible to a 90 degree angle, and there was no evident limitation of lateral motion. The lumbar muscles seemed "softer" on palpation.

Two days later there were beginning signs of a return of the lumbar rigidity. The trunk could be flexed only to a 110 degree angle, and accordingly the neostigmine-atropine injection was repeated, with subsequent relief. Following this second injection there was no recurrence of symptoms, and the patient was discharged.

Case 5.—A white man aged 32 stated that, while performing his duties as a fireman, he fell down a flight of stairs, pinning his right leg under his left and injuring his right knee, which became swollen and painful.

Physical examination was irrelevant save for the local condition. The right knee area was edematous and the leg flexed

to a 110 degree angle. Any attempt at manipulation evoked further pain. The hamstring muscles were hard; evidence of muscle spasm. Roentgenograms revealed no abnormality.

The usual dose of 2 cc. of neostigmine methylsulfate 1 : 2,000 with 0.6 mg. of atropine sulfate was given subcutaneously. Five minutes later the patient was able to extend the right leg almost completely without discomfort. The effects persisted for almost two days, after which there was a gradual return of hamstring spasticity. Accordingly the neostigmine-atropine injection was continued every other day for another week, while other treatment relieved the bony injury.

CASE 6.—A white female aged 35 stated that she had had rheumatoid arthritis for the past nine months. She had been confined to bed for the last four months, save for bathroom privileges, during which time she was subjected to the usual measures designed for symptomatic relief—salicylates, alkalization and opiates. All her teeth had been extracted, since it was believed that they were a focus of infection.

Physical examination revealed a more or less generalized stiffness of the joints throughout the body. The patient was unable to move her arms, forearms, legs, feet and toes. Assistance was required for walking, feeding, dressing and other movements.

Therapy consisted of neostigmine methylsulfate 1 : 2,000 twice daily for three days, the dose ranging from 0.5 to 2 cc., depending on the degree of stiffness present. Atropine sulfate 0.4 mg. was given with each dose of neostigmine methylsulfate. Concurrently the patient received capsules containing codeine sulfate ½ grain (0.032 Gm.), sodium salicylate 5 grains (0.32 Gm.) and acetylsalicylic acid 5 grains every three to four hours. On the ninth and eleventh days a sterile hypodermic injection was given to rule out any psychic factor. No relief followed these.

Thereafter daily injections of 2 cc. of neostigmine methylsulfate 1 : 2,000 with 0.6 mg. of atropine sulfate were given for eleven days. The results were remarkable in that there was a considerable degree of relaxation of spasm of the muscles surrounding the affected joints. By the end of the third day the patient was able to arise from her bed without assistance, and on the sixth day she was able to use a broom in a sweeping motion.

Following about two weeks of neostigmine treatment all therapy was discontinued for sixteen days, following which there was a relapse, which was relieved by additional neostigmine-atropine injections.

CASE 7.—O. A., a white man aged 51, complained of pain in the neck and back of six years' duration. The patient, who was round shouldered, was unable to rotate his neck or bend his trunk anteriorly. In order to turn his head he was forced to rotate his entire body.

Therapy consisted of 1 cc. of neostigmine methylsulfate 1 : 2,000 with 0.6 mg. of atropine sulfate subcutaneously every two to three days, in addition to 30 mg. of neostigmine bromide with 0.6 cc. of tincture of belladonna by mouth three times daily. There was no objective improvement after one month, although the patient claimed he felt somewhat improved, especially in dry weather. This case must be considered a therapeutic failure.

CASE 8.—J. K., a policeman aged 38, gave a history of having had a sudden onset of severe pain in the left shoulder three months before. A diagnosis of acute bursitis was made, and despite symptomatic treatment there was no relief, the patient being unable to raise his arm above shoulder level.

The patient was well developed and well nourished, ambulatory and in no apparent discomfort. Although the left arm could be abducted beyond 90 degrees to 110 degrees, this passive movement was accompanied by intense pain and evidence of muscle spasm.

Therapy consisted in 2 cc. of neostigmine methylsulfate 1 : 2,000 with 0.6 mg. of atropine sulfate subcutaneously. Eight minutes later the patient was able on his own accord to abduct his arm to a 180 degree angle with slight difficulty but with no pain. The neostigmine-atropine injection was repeated every third day for three doses. After that an injection was given each week, with complete recovery in six weeks.

COMMENT AND CONCLUSIONS

We believe that the medical profession has heretofore overlooked a very important symptom of rheumatoid arthritis, namely muscle spasm. While certain authors have previously called attention to this phenomenon, it has been generally neglected and certainly no especial therapy has been directed against it. Since it is now conceded that our present therapy for the joint lesions is at best inadequate, it becomes especially important to treat the accompanying muscle spasm, which we are convinced is one of the primary sources of the severe pain experienced by sufferers from this disease. Certainly if we cannot cure the underlying condition we should do our utmost to make the patient comfortable.

In our experience neostigmine is a far more efficacious remedy for relieving such spasm than any other medication which has been previously employed. Furthermore, we are of the opinion that neostigmine acts in a more physiologic manner than the analgesics, which do no more than depress the pain centers in the central nervous system and leave the underlying disturbed physiologic function unchanged. Although it is not known definitely just how neostigmine exerts its beneficial action, we do know that it is in all probability not directly on the myoneural junction. Were the latter the case no benefit would ensue, for atropine is known to counteract this action. Therefore neostigmine here probably acts directly on the various units of the central nervous system, perhaps in accord with the findings exemplified by Kabat and Knapp.[2]

Even though we are not certain of the manner in which neostigmine acts to relieve the muscle spasm and thereby the pain in cases of rheumatoid arthritis and allied disorders, we firmly advocate the extension of its use. In general, we suggest that from 1 to 2 cc. of neostigmine methylsulfate 1 : 2,000 with suitable doses of atropine to prevent undesired side effects (found in a certain percentage of cases) be given subcutaneously three or four times weekly. Although not used in all of our earlier cases, we advocate that from 15 to 30 mg. of neostigmine bromide be given by mouth three times daily in addition to the parenteral dose.

Of the 19 cases in our preliminary series, 8 of which are reported here in detail, a total of 13 responded favorably. In the remaining 6 cases there was either slight or no relief from neostigmine. Space does not permit us to describe the other 11 cases, but we have chosen those which we believe are most representative.

SUMMARY

1. Neostigmine has been used in treating 19 cases of rheumatoid arthritis and similarly related conditions. Thirteen cases gave a favorable response.

2. Neostigmine is believed to cause a relaxation of muscle spasm, even though it has persisted for many years. The drug has no demonstrable effect on the pain produced by the joint lesion. Active as well as passive motion in the affected joints is more easily carried out with less pain.

3. The effect of neostigmine given subcutaneously is rapid (within three to fifteen minutes after administration) and may persist for several days.

4. We believe that neostigmine bromide orally should be administered concurrently so as to obtain a more prolonged effect during the interim between injections.

5. It is to be hoped that this report on the neostigmine treatment of spasm associated with rheumatoid arthritis will encourage clinicians to study the problem further. Meantime we advocate the experimental use of the drug in all cases similar to those herein described.

AN UNUSUAL MODE OF ACTION OF DIGITALIS IN AURICULAR FIBRILLATION

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In the practice of medicine there are few therapeutic triumphs that equal the spectacular results achieved through digitalization of a patient in congestive heart failure with auricular fibrillation. In a few days the gloom of the sickbed is dispersed and a new lease on life granted. To the great satisfaction of the patient and his distraught relatives, with no lesser satisfaction to the physician himself, the picture of despair is superseded by that of new hope. A sufferer who has been spending night after night propped up in a chair panting for breath and utterly exhausted by the never ending struggle for air can now breathe without effort. He need no longer look covetously at his bed, knowing that there he can find no rest. On the contrary, in bed he can now repose with ease and comfort. Every ounce of remaining strength need no longer be spent for the sole purpose of labored breathing. And all this is accomplished through the judicious use of a truly miraculous drug, digitalis.

For the present, little does it matter that the cure, in the ordinary sense of the word, is not attained, and the inevitable doom is only postponed. Also little does it matter that the ominous cycle of delirium cordis is not broken, at least in the auricles; for one may acquiesce in the security of well founded knowledge that the vicious forces are chained in the quarters where they can do little harm; that an insurmountable barrier is erected between auricles and ventricles, so that the untamed forces cannot break loose, invade the latter chambers and corrupt the rehabilitated circulation.

In auricular fibrillation, then, digitalis slows the ventricular rate, while fibrillation in the auricles remains unaffected. Although this is a well established and widely known fact, there is, however, no unanimity of opinion as to the exact mechanism responsible for this slowing. There are some who believe the effect to be due to direct action of the drug on the decompensated myocardium—digitalis enhances the force of muscular contraction, thereby increasing the refractory period of the muscle fibers and thus leading to decrease in their excitability to the auricular impulses. In addition, with the improvement in the state of circulation, and consequently in the coronary flow, the partial anoxemia of the heart muscle is relieved and its irritability thus reduced—the ventricles become less responsive to the stream of stimuli reaching them through the junctional tissue from the auricles. This view is in accord with the contention of some clinicians that the tachycardia of auricular fibrillation in patients with heart failure secondary to intrinsic cardiac pathologic changes is the result of the failure itself. But there are others who believe that the ventricular slowing results from the functional block produced by digitalis. Here again the opinion is divided as to the manner in which the block is produced. Two possibilities are known to exist: 1. Although the conducting fibers of the bundle of His constitute a specialized type of myocardial tissue, they share with the latter the cardiotonic effect of digitalis. This effect fundamentally consists in strengthening the muscular contraction with the concomitant increase in refractory period and the corresponding decrease in the rate of conduction. Thus the block may be produced by the drug through the direct action on the conducting tissue. This explanation, promulgated by Cushny, is shared perhaps by the majority of physiologists, pharmacologists and clinicians. 2. The block may be of vagal origin entirely (Mackenzie). Porter [1] contends that the failure to demonstrate the vagal effect by other workers was due to the employment of inadequate doses of atropine used in the attempts to paralyze the vagus endings and thus effect the "vagal release." By administering large doses of atropine intravenously (1/25 grain, or 0.0025 Gm.) in cases of ventricular slowing under digitalis therapy he succeeded in reproducing promptly the rapid ventricular rate of the predigitalization period, thus demonstrating to his satisfaction that the original slowing of the ventricles was caused by the action of the drug on the conducting system via the vagus. On the other hand, Gold and his associates [2] have succeeded in showing that, while the slowing produced by small doses of digitalis was apparently due to vagal stimulation with adequate doses of atropine increasing the heart rate, after full doses of digitalis atropine was found to be no longer effective in increasing the ventricular rate, the ventricular slowing being apparently due to extravagal action of digitalis.

It is not my purpose in this article to dwell at great length on the controversial subject of digitalis-induced slowing of the ventricular rate in cases of auricular fibrillation. It is quite likely that both vagal and extravagal influences are operative and mutually contributive toward the end result and that the three points of view mentioned are not antagonistic or mutually exclusive but rather supplement one another. Whatever may be the mechanism of digitalis-induced ventricular slowing in auricular fibrillation, the fact remains that as a generally accepted postulate the drug does not abolish the fibrillation itself; the change produced is in regard to the heart rate but not the rhythm. Goodman and Gillman [3] give the following explanation for this mode of action of digitalis: "The auricular rate may increase or decrease but is usually speeded both by the muscular and vagal effects of digitalis. Both digitalis and quinidine increase the refractory period and slow the conduction in the auricular muscle but accomplish this by entirely different means. It may be asked, legitimately, therefore, why digitalis does not stop auricular fibrillation. The answer must lie in the fact that the glycoside does not sufficiently lengthen the refractory period of auricular muscle to interrupt the circus movement. Such an action of digitalis can arise only from an increase in the force of auricular contraction. Digitalis may not be able to accomplish this in a dilated fibrillating auricle. Furthermore, large doses increase muscular irritability and thus shorten the refractory phase. Likewise vagal stimulation caused by the drug also tends to shorten

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1. Porter, E.: Therapeutic Use of Drugs of Digitalis Group, Quart. J. Med. **2**: 33 (Jan.) 1933.

2. Gold, H.; Kwit, N. T.; Otto, K., and Fox, T.: On the Vagal and Extravagal Factors in Cardiac Slowing by Digitalis in Patients with Auricular Fibrillation, J. Clin. Investigation **18**: 429 (July) 1939.

3. Goodman, L., and Gillman, A.: The Pharmacological Basis of Therapeutics, New York, The Macmillan Company, 1941, p. 532.

the refractory period. These combined effects fix and perpetuate, if not actually accelerate, the rate of the auricular fibrillation."

In the standard textbooks of medicine, therapeutics or pharmacology there is no mention made of the possibility of digitalis effecting the change in the rhythm itself, i. e., causing in some patients with auricular fibrillation reversal to normal sinus mechanism. Luten [4] states that whether or not the drug may at times terminate an attack is open to question. He adds "The cessation of the attack, if it occurs, is rare." However, I have encountered 2 cases of auricular fibrillation, with cessation of the arrhythmia in both while on digitalis therapy. On search of literature I have found one other report [5] with somewhat similar observation.

REPORT OF CASES

CASE 1.—C. B. J., a white man aged 34, American, a truck driver, was admitted to the hospital on July 2, 1943 for treatment of aphasia and loss of function in the right arm and leg of one week's duration. The parents stated that the patient had chorea at the age of 8 and that in the course of the last couple of years he had complained of some exertional dyspnea.

Physical examination revealed that the patient was well developed and well nourished. He had motor aphasia and right-sided hemiplegia. There was no dyspnea, cyanosis or edema present. The lungs were normal on palpation, percussion and auscultation. The heart borders were within normal limits on percussion. The pulmonic second sound was somewhat louder than the aortic second sound. The first sound at the apex was accentuated, and a low-pitched diastolic rumble, localized to the region of the apex, could be heard. The rhythm was regular with a rate of 60. The blood pressure was 120 systolic, 50 diastolic.

The urinalysis did not reveal anything abnormal. The red blood cell count was 4,650,000, hemoglobin 14.5 Gm., platelets 370,000 and white blood cell count 10,200, with 71 per cent polymorphonuclears. The blood Wassermann reaction was negative. The x-ray examination of the chest demonstrated some cardiac enlargement, with the greatest transverse diameter of 16.3 cm. within the rib cage of 32 cm. The left border presented a straight line from the aortic knob to the apex, with some prominence over the left auricular region.

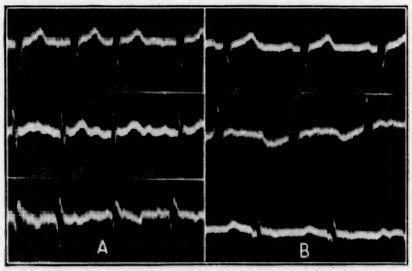

Fig. 1 (case 1).—*a*, before and *b*, after digitalization.

It was thought that the neurologic findings were on an embolic basis, secondary to rheumatic heart disease with mitral stenosis. However, and in spite of negative serologic tests on the blood, it was decided to rule out the possibility of cerebrovascular syphilis as an etiologic factor of the patient's neurologic disability. A spinal puncture was done, but the serologic test on the spinal fluid also gave negative results.

On August 20 it was found on auscultation of the heart that there was now present a totally irregular rhythm with a rate of 120. The electrocardiogram demonstrated an auricular fibrillation (fig. 1 *a*). The patient was started on digitalis. On August 25, after he had had a total of 27 grains (1.65 Gm.) of digitalis, the rhythm reverted back to sinus mechanism (fig. 1 *b*). The maintenance dose was 1½ grains (0.1 Gm.) and the rhythm was still regular on August 31, when the patient left the hospital.

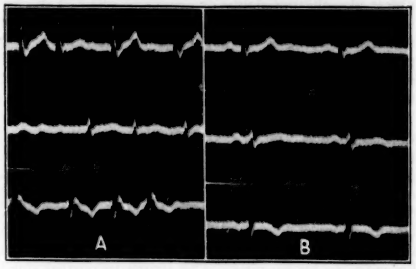

Fig. 2 (case 2).—*a*, before and *b*, after digitalization.

CASE 2.—R. F., a white man aged 56, American, a hospital attendant, was admitted to the hospital on Aug. 27, 1943 with complaints of nervousness, loss of weight, slight exertional dyspnea, palpitations and a feeling of fulness in the neck of several weeks' duration. He had diphtheria at 10 and mumps at 30 years of age. There was no history of any rheumatic infection in the past.

On physical examination the patient was seen to be well developed and rather slender; he did not appear to be in any acute distress. There was no exophthalmos or lid lag. The thyroid was symmetrically enlarged; no bruit could be heard over it. The lungs were clear. The heart was within normal limits as to size on percussion. The tones were of only fair quality, somewhat distant and totally irregular, with a rate of 122. The aortic second sound and the pulmonic second sound were equal. There was a faint systolic murmur at the apex. No diastolic murmurs could be heard. The radial pulses were equal and totally irregular, with a pulse deficit of about 10. The blood pressure was 145/65. The liver could not be palpated. There was no dependent edema noted.

The urinalysis showed the presence of a trace of albumin and 1 plus white blood cells. The red blood count was 4.7 million and the white blood cell count was 7,400. The blood Wassermann reaction was negative. The basal metabolic rate was plus 7 and plus 11. Circulation time with decholin was 21 seconds. The x-ray examination of the chest revealed the greatest transverse diameter of the heart to be 14.7 cm. within a rib cage of 30.5 cm. The electrocardiogram demonstrated auricular fibrillation (fig. 2 *a*).

In spite of a palpable thyroid it was thought that his auricular fibrillation was not on a thyrotoxic basis. The history, the clinical appearance of the patient, the circulation time and the basal metabolic determination were all not those to be expected in a case of thyrotoxicosis. On September 1 the patient was started on digitalis. On the 6th, after the administration of a total of 24 grains (1.6 Gm.) of digitalis, the heart rate was found to be regular, and the electrocardiogram showed a reversal to sinus rhythm (fig. 2 *b*). The rhythm was still regular at the time of discharge of the patient from the hospital on October 2, with the patient continuing on a maintenance dose of digitalis.

4. Luten, D.: The Clinical Use of Digitalis, Springfield, Ill., Charles C Thomas, Publisher, 1936, p. 120.

5. Schwartz, S.: The effect of Digitalis on Premature Auricular Contractions Associated with Attacks of Paroxysmal Auricular Fibrillation: The Use of the Drug in the Treatment and Prevention of Certain Forms of These Arrhythmias. Am. Heart J. **6**: 458 (April) 1931.

COMMENT

The first patient had mitral stenosis. The condition of the second patient was not definitely diagnosed. Thyrotoxicosis was excluded on clinical grounds. He might have had rheumatic heart disease, even in the absence of a rheumatic history or any diastolic murmurs; also the possibility of degenerative heart disease should have been entertained. Or this patient might well have belonged to that group of individuals with paroxysmal auricular fibrillation in whom heart disease cannot be demonstrated either intra vitam or post mortem.

The time of onset of the first patient's auricular fibrillation was known, as it developed while he was under observation in the hospital. The arrhythmia terminated on the sixth day after the administration of a total of 27 grains (1.75 Gm.) of digitalis. The duration of the second patient's arrhythmia could not be ascertained. From the history it might be surmised that it was probably present for several weeks prior to his entry to the hospital. The return to normal sinus rhythm took place also on the sixth day after the beginning of treatment and after the administration of a total of 24 grains (1.55 Gm.) of the drug.

Auricular fibrillation is arbitrarily classified by Friedlander and Levine [6] as either paroxysmal or "permanent," depending on whether it lasts from a few hours to a week or longer. They feel that an attack lasting longer than seven days should be classified as "permanent" because "it was assumed that any attack lasting more than a week would not be likely to cease spontaneously." Paroxysms are well known to terminate spontaneously only too frequently. Even in cases of arrhythmia lasting a few months or a year the spontaneous reversal to normal sinus mechanism has been observed. A case of spontaneous cessation of auricular fibrillation of twenty-two months' duration was reported by Burch.[7] It is difficult, therefore, if not impossible, to be able to state definitely whether the termination of an attack in any patient with auricular fibrillation treated with digitalis is directly attributable to the drug or is rather spontaneous. However, it will be noted in both cases here reported that the return to normal sinus mechanism took place only after the administration of what could be considered as an approximation to a full digitalization dose. Whether in each case it was merely a coincidence or rather a cause and effect relationship remains highly speculative. It may be said that the latter would appear to be more probable than consecutively repeated coincidental relationships.

A reference has already been made to one other report in the literature with observations on this unusual mode of action of digitalis. Seven patients observed by Schwartz [5] from Montefiore Hospital, New York, with organic heart disease and signs of congestive failure, had been subject to frequent attacks of auricular fibrillation. These attacks were invariably preceded for several days by auricular extrasystoles. All patients showed restoration to sinus mechanism after the administration of single large doses of digitalis within a short time after the auricular fibrillation was discovered. For each patient "it was possible to show a direct relationship between the administration of a single large dose of digitalis and the disappearance of auricular fibrillation, with restoration of normal sinus rhythm following the use of the drug." Strangely enough, when the patients were digitalized slowly, receiving 3 cc. of the tincture daily for five to seven days, although ventricular slowing resulted the rhythm remained unchanged. Attacks of auricular fibrillation could be prevented by digitalization during the period of sinus rhythm or auricular extrasystoles, the latter arrhythmia being invariably followed by fibrillation in nondigitalized patients. These were thought by Schwartz "to form a distinct group among patients with heart disease because of the unusual response to variable doses of digitalis in the presence of auricular premature beats and auricular fibrillation."

The observations on the 2 cases reported here differ in several respects from those in the series described by Schwartz: 1. In the cases here presented there was no evidence of congestive heart failure. 2. The period of auricular premature beats immediately, and invariably, preceding the onset of fibrillation was not demonstrated. 3. Restoration to normal rhythm took place following a relatively slow method of digitalization, taking six days in each instance, a form of therapy which in Schwartz's cases was not productive of the same results, as in his cases cessation of auricular fibrillation ensued only on the exhibition of single large doses of the drug.

I have no explanation to offer for this unusual mode of action of digitalis in auricular fibrillation. The action of the drug in the auricles is complex and not too well understood.

SUMMARY

On administration of digitalis to patients with auricular fibrillation and rapid heart rate the objective sought is the slowing of the ventricular rate. The desired effect is usually easily accomplished in the presence of perpetuation of the arrhythmia itself.

In 2 cases of auricular fibrillation observed in the course of digitalis therapy, not only did the slowing of the ventricular rate occur, but also a reversal to sinus mechanism took place.

On search of the literature a report with similar observations was found.

No explanation is offered for this unusual mode of action of digitalis in auricular fibrillation.

6. Friedlander, R. D., and Levine, S. A.: Auricular Fibrillation and Auricular Flutter Without Evidence of Organic Heart Disease, New England J. Med. **211**: 624 (Oct. 4) 1934.

7. Burch, G. E.: Auricular Fibrillation of Twenty-Two Months' Duration with Return to Normal Sinus Mechanism Without Aid of Quinidine, Am. Heart J. **18**: 102 (July) 1939.

Occupational Mercurialism Among Miners in the Eighteenth Century.—Several interesting observations relating to occupational mercurialism among miners were made during the 18th century. In 1719 Bernard de Jussein presented a memoir to the Academy of Sciences in which he reported the situation of the workers in the Almaden mercury mines of Spain. Both free and slave labor were employed there, and both groups of workers suffered from mercury poisoning. Nevertheless the free miners, since they were at liberty to leave the mines and kept their persons clean, exhibited no evidence of mercurialism except for slight tremors. The slaves, on the other hand, imprisoned in their unclean quarters and without any real means of cleaning themselves, were afflicted with swellings of the parotid glands, stomatitis, salivation and pustular rashes. Giovanni Scopoli described mercury poisoning, with the characteristic trembling, among the miners around Alto Isonzo.—Rosen, George: The History of Miners' Diseases, New York, Schuman's, 1943.

THE EFFECTIVENESS AND SAFETY OF MERCUPURIN ADMINISTERED ORALLY

IN THE TREATMENT OF CONGESTIVE HEART FAILURE

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Although the value and use of mercurial diuretics for the treatment of advanced congestive heart failure has been thoroughly established, there remains the necessity for controlled evaluation of the various preparations useful for this purpose. Studies on mercupurin and salyrgan,[1] mercurial suppositories[2] and orally administered salyrgan-theophylline[3] have been reported from this laboratory. It is our purpose in this paper to present data on the effectiveness and safety of Mercupurin[4] administered orally in the routine treatment of congestive heart failure.

STUDIES ON HOSPITALIZED PATIENTS

A total of 42 patients was studied, of whom 32 were hospitalized and 12 were ambulatory; 2 patients were included in both groups. For the hospitalized patients two schemes of administration of the Mercupurin tablets were utilized. Whenever a diuretic was considered to be necessary, either a single dose of 5 tablets (with the exception of 1 patient who received 6 tablets) was given in the morning or the patient was given multiple doses consisting of 2 tablets three times daily for two to four days. In 1 instance the administration of the tablets was continued for seven days. Regardless of the scheme of administration, a preliminary control period was established during which time the maximum effect of bed rest, oxygen, sedatives, limitation of fluid intake, dietary restriction and digitalis and ammonium chloride whenever given maintenance doses was ascertained. The weight curve was followed in preference to the measurement of urinary output, because it has been proved to be a more accurate and sensitive index of diuretic response.[5] The urine was examined at frequent intervals for albumin and formed elements.

Table 1 summarizes the results in the hospitalized group of patients. A single dose of 5 Mercupurin tablets was given 30 times to 23 patients. A loss of 3 pounds (1.3 Kg.) or more in body weight within forty-eight hours after the administration of the diuretic was considered a satisfactory response. This response was obtained in 18 trials (60 per cent), or 16 patients (69 per cent). With the exception of patients 3, 10 and 22, the lack of satisfactory diuretic response could be attributed to the fact that they were not receiving either ammonium chloride or digitalis. For example, patient 1 responded when ammonium chloride was administered simultaneously with the Mercupurin tablets, and patient 9 stopped responding when digitalis and ammonium chloride were discontinued. In a few instances, such as in patients 10 and 11, the degree of edema was so slight that the lack of response was not surprising.

The multiple dose method was tried 23 times with 17 patients (table 1). A good diuretic response was obtained in 16 trials (69 per cent) and 12 patients (71 per cent). The lack of response in patient 3 is unexplainable. This patient also failed to respond to the single dose method. The failure in cases 20 and 31 could be attributed to the very slight degree of edema, while in case 23 the degree of failure was progressively worse because of lack of digitalis. The failure of the third trial in case 22 while the previous 2 trials were successful is also unexplainable. In patient 25 the lack of response may be attributed to severe failure precipitated by pneumonia. The patient also failed to respond to Mercupurin administered intravenously. However, previously when ambulatory the response to the tablets was very satisfactory.

Diuresis by the single dose method usually began within four to twelve hours and in the majority of instances was practically complete at the end of twenty-four hours. However, the diuresis persisted in several cases for forty-eight hours or longer. By the multiple dose method diuresis was usually noted within twenty-four hours but did not reach its peak before forty-eight or seventy-two hours.

STUDIES ON AMBULATORY PATIENTS

Twelve ambulatory patients whose severe congestive heart failure could not be controlled with a maintenance dose of a digitalis preparation were given 102 trials with Mercupurin tablets. Complete protocols summarizing each case are presented in table 2. Either patients were advised to start taking the tablets the day after the clinic visit at which the examination showed that a mercurial diuretic was indicated or the patient was given Mercupurin intravenously at the time of the clinic visit and advised to take the tablets when the edema had reaccumulated.

In general, giving the drug in doses of 1 or 2 tablets three times daily for two to four days was a satisfactory means of producing diuresis. It was possible to extend the time necessary for clinic visits for those patients who would ordinarily have required Mercupurin at weekly intervals, since the tablets definitely produced a satisfactory response sufficient to forestall the use of the parenteral preparation or delay the accumulation of edema. In only 8 of the 102 trials was the response considered to be ineffective for this purpose. The tablets were particularly useful if the patient could not be controlled by weekly injections of Mercupurin. The administration of the tablets in the period between clinic visits diminished or prevented the severe symptoms of congestive heart failure. Thus patient 2 remained free from paroxysmal dyspnea for the first time in a year, and patient 7, who previously had several hospital admissions for severe congestive heart failure, was able to remain ambulatory with minimal edema for over eight months.

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1. DeGraff, A. C.; Nadler, J. E., and Batterman, R. C.: A Study of the Diuretic Effect of Mercupurin in Man, Am. J. M. Sc. **191**: 526 (April) 1936.

2. Brightman, I. J., and Batterman, R. C.: The Treatment of Edema by Rectal Administration of Diuretics, J. Lab. & Clin. Med. **25**: 1038 (July) 1940.

3. Batterman, R. C.; DeGraff, A. C., and Rose, O. A.: Treatment of Congestive Heart Failure with an Orally Administered Mercurial Diuretic, Am. Heart J. **21**: 98 (Jan.) 1941.

4. Each tablet contains 100 mg. of Mercupurin powder equivalent to 30 mg. of mercury and 27 mg. of anhydrous theophylline, as compared with 135 mg. of Mercupurin represented in 1 cc. of the parenteral solution. Mercupurin tablets were supplied by Campbell Products, Inc.

5. DeGraff, Nadler and Batterman,[1] Brightman and Batterman,[2] Batterman, DeGraff and Rose.[3]

TABLE 1.—*Effectiveness of Mercupurin Administered Orally to Patients Hospitalized for Congestive Heart Failure*

No. Case	Diagnosis	Age	Digitalis	Ammonium Chloride	Degree of Failure	Scheme of Administration	Weight Before	Weight After	Total Weight Loss	Days for Diuresis	Comment
1. J. W.	Arteriosclerosis, hypertension, enlarged heart, myocardial fibrosis, coronary sclerosis, auricular fibrillation	65	Yes	No	+	5 tablets; single dose	211½	213¾	...	None	
				1 Gm. t. i. d.	+	5 tablets; single dose	216¼	211½	4¾	1	Good diuresis
2. M. S.	Arteriosclerosis, hypertension, enlarged heart, myocardial fibrosis, coronary sclerosis, regular sinus rhythm, bundle branch block	67	Yes	1 Gm. t. i. d.	+++	5 tablets; single dose	119¾	113¾	6	2	Good diuresis
				1 Gm. t. i. d.	+++	2 tablets t. i. d. for 4 days	112	103½	8½	4	Mild diarrhea developed on 4th day; proctoscopy revealed no pathologic condition
3. E. H.	Unknown, enlarged heart, regular sinus rhythm	32	Yes	1 Gm. t. i. d.	++	5 tablets; single dose	244½	243	1½	1	Diarrhea for 24 hours
				1 Gm. t. i. d.	++	2 tablets t. i. d. for 2 days	228¼	228	...	None	No gastrointestinal upset
4. F. B.	Arteriosclerosis, enlarged heart, coronary sclerosis, myocardial fibrosis, regular sinus rhythm	63	No	No	+++	5 tablets; single dose	145½	139	6½	2	Good diuresis; initiated diuresis, which persisted until patient lost all signs of failure; basal weight, 116
5. N. S.	Hypertension, arteriosclerosis, enlarged heart, old myocardial infarct, coronary sclerosis, regular sinus rhythm	45	Yes	1 Gm. t. i. d.	+++	6 tablets; single dose	173½	169¼	3¾	2	Mild diuresis; no gastrointestinal upset
				1 Gm. t. i. d.	++	5 tablets; single dose	177½	171¼	6¼	1	Good diuresis
				1 Gm t. i. d.	++	2 tablets t. i. d. for 2 days	175	166½	8½	3	Good diuresis
6. S. M.	Unknown, enlarged heart, regular sinus rhythm	40	No	No	+++	5 tablets; single dose	176	174¼	1¾	1	
7. A. E.	Arteriosclerosis, enlarged heart coronary sclerosis, myocardial fibrosis, auricular fibrillation	70	Yes	1 Gm. t. i. d.	++	5 tablets; single dose	181	172	9	2	Good diuresis; maximum loss of weight in 2d 24 hour period
8. A. D.	Arteriosclerosis, enlarged heart, coronary sclerosis, myocardial fibrosis, auricular fibrillation	68	Yes	No	++	5 tablets; single dose	128½	122½	6	3	Good diuresis; initiated diuresis, which persisted until basal weight of 106½ was reached
9 W. J.	Hypertension, enlarged heart, regular sinus rhythm	47	Yes	1 Gm. t. i. d.	+++	5 tablets; single dose	152	149	3	1	Slight nausea, abdominal colic; diarrhea for 24 hours
			No	No	+++	5 tablets; single dose	151¾	150	1¾	1	No gastrointestinal upset
			Yes	1 Gm. t. i. d.	++	2 tablets t. i. d. for 4 days	146½	143½	3	4	
10. J. G.	Rheumatic fever, enlarged heart, mitral stenosis, mitral insufficiency, aortic stenosis, aortic insufficiency, auricular fibrillation	35	Yes	1 Gm. t. i. d.	+	5 tablets; single dose	117¼	116½	..	None	Diarrhea for 24 hours
11. L. G.	Rheumatic fever, enlarged heart, mitral insufficiency, mitral stenosis, aortic insufficiency, auricular fibrillation	44	Yes	No	+	5 tablets; single dose	128¼	129¼	..	None	Slight nausea
12. P. L.	Hypertension, arteriosclerosis, enlarged heart, coronary sclerosis, myocardial fibrosis, regular sinus rhythm	61	Yes	1 Gm. t. i. d.	+++	5 tablets; single dose	175¾	171¼	4½	2	Good diuresis; followed as ambulatory patient
13. C. S.	Hypertension, enlarged heart, regular sinus rhythm	49	No	1 Gm. t. i. d.	+++	5 tablets; single dose	177	172½	4½	2	Good diuresis
				1 Gm. t. i. d.	.....	5 tablets; single dose	179	173½	5½	1	Good diuresis; followed as ambulatory patient
14. T. F.	Unknown, enlarged heart, regular sinus rhythm	42	Yes	No	+++	2 tablets t. i. d. for 5 days	172	158½	13½	5	Good diuresis; initiated in first 24 hours
15. W. D.	Hypertension, arteriosclerosis, enlarged heart, coronary sclerosis, myocardial fibrosis, regular sinus rhythm	57	No	1 Gm. t. i. d.	+++	5 tablets; single dose	184¾	182¾	2	2	Mild diuresis; patient digitalized after 48 hours
16. E. B.	Hypertension, arteriosclerosis, enlarged heart, coronary sclerosis, myocardial fibrosis, regular sinus rhythm	54	No	1 Gm. t. i. d.	+++	5 tablets; single dose	180½	173	7½	1	Good diuresis
				1 Gm. t. i. d.	+++	5 tablets; single dose	172½	167¾	4¾	1	
				1 Gm. t. i. d.	+++	5 tablets; single dose	165¾	159	6¾	1	Good diuresis
17. M. W.	Arteriosclerosis, enlarged heart, coronary sclerosis, myocardial fibrosis, auricular fibrillation	68	No	No	++	5 tablets; single dose	124	121	3	1	
18. A. L.	Arteriosclerosis, hypertension, enlarged heart, coronary sclerosis, myocardial fibrosis, regular sinus rhythm, bundle branch block	68	No	No	+++	5 tablets; single dose	144½	142½	2	1	
			No	No	+++	5 tablets; single dose	140¼	138	1¾	2	Patient digitalized after this attempt
			Yes	No	++	2 tablets t. i. d. for 2 days	122¼	116¾	5½	3	Treated on 2d admission; good diuresis with complete removal of failure
19. C. G.	Hypertension, arteriosclerosis, enlarged heart, coronary sclerosis, myocardial fibrosis, regular sinus rhythm	?	Yes	No	+	5 tablets; single dose	120	120	..	None	
20. L. B.	Arteriosclerosis, enlarged heart, coronary sclerosis, myocardial fibrosis, auricular fibrillation	78	Yes	1 Gm. t. i. d.	+	2 tablets t. i. d. for 2 days	154	151½	2½	2	
				1 Gm. t. i. d.	+	5 tablets; single dose	153	150	3	2	
21. E. P.	Hypertension, arteriosclerosis, enlarged heart, coronary sclerosis, myocardial fibrosis, auricular fibrillation	61	No	No	+++	5 tablets; single dose	164¼	159	5¼	3	Delayed diuresis in 2d 24 hour period; initiated diuresis with total weight loss of 9 pounds
22. S. R.	Rheumatic fever, enlarged heart, mitral stenosis, mitral insufficiency, regular sinus rhythm	56	Yes	1 Gm. t. i. d.	+++	5 tablets; single dose	142	143	None	None	
				1 Gm. t. i. d.	+++	2 tablets t. i. d. for 2 days	142½	139¼	3¼	2	Good diuresis
				1 Gm. t. i. d.	+++	2 tablets t. i. d. for 4 days	141½	134½	7	4	Good diuresis
				1 Gm. t. i. d.	++	2 tablets t. i. d. for 3 days	133	133½	None	None	

TABLE 1.—*Effectiveness of Mercupurin Administered Orally to Patients Hospitalized for Congestive Heart Failure—Continued*

No. Case	Diagnosis	Age	Digitalis	Ammonium Chloride	Degree of Failure	Scheme of Administration	Weight Before	Weight After	Total Weight Loss	Days for Diuresis	Comment
23. G. C.	Hypertension, arteriosclerosis, enlarged heart, myocardial fibrosis, coronary sclerosis, regular sinus rhythm	70	No	1 Gm. t. i. d.	+++	2 tablets t. i. d. for 3 days	144	141½	2½	3	Diarrhea, nausea and vomiting on 3d day of administration; also in severe congestive heart failure
24. L. P.	Arteriosclerosis, enlarged heart, coronary sclerosis, myocardial fibrosis, regular sinus rhythm	55	Yes	1 Gm. t. i. d.	++	5 tablets; single dose	164	158	6	2	Good diuresis
25. N. F.	Rheumatic fever, enlarged heart, mitral stenosis, mitral insufficiency, regular sinus rhythm	39	Yes	1 Gm. t. i. d.	+++	2 tablets t. i. d. for 4 days	147½	145½	2	1	Patient in failure because of pneumonia; previously responded while ambulatory
				1 Gm. t. i. d.	+++	2 tablets t. i. d. for 3 days	138¾	138¾	0	None	Continued with intravenous mercupurin with poor response
26. J. S.	Arteriosclerosis, enlarged heart, coronary sclerosis, myocardial fibrosis, auricular fibrillation	72	Yes	1 Gm. t. i. d.	+++	2 tablets t. i. d. for 3 days	243	227¾	15¼	4	Excellent response; gained weight when tablets were discontinued
				1 Gm. t. i. d.	+++	5 tablets; single dose	230	228	2	1	
				1 Gm. t. i. d.	+++	2 tablets t. i. d. for 3 days	228	210	18	3	Excellent diuresis; loss of 12 lbs. in 1st 24 hours
				1 Gm. t. i. d.	++	2 tablets t. i. d. for 3 days	208	199½	8½	4	Excellent diuresis
27. H. S.	Arteriosclerosis, enlarged heart, coronary sclerosis, myocardial fibrosis, auricular fibrillation	66	Yes	No	+++	2 tablets t. i. d. for 3 days	175	159	16	5	Excellent response; initiated diuresis for total weight loss of 30 lbs. of edema fluid
28. I. A.	Hypertension, enlarged heart, regular sinus rhythm	39	Yes	No	++	2 tablets t. i. d. for 3 days	114	107¼	6¾	4	
29. M. H.	Arteriosclerosis, hypertension, enlarged heart, coronary sclerosis, myocardial fibrosis, auricular fibrillation	65	Yes	1 Gm. t. i. d.	++	2 tablets t. i. d. for 4 days	168	160	8	4	
				1 Gm. t. i. d.	++	2 tablets t. i. d. for 2 days	160½	153½	7	3	
30. A. D.	Arteriosclerosis, enlarged heart, coronary sclerosis, myocardial fibrosis, regular sinus rhythm	50	Yes	No	++	2 tablets t. i. d. for 7 days	152¾	146¾	6	5	Response to intravenous mercupurin also poor (3¾ lbs.)
31. M. B.	Hypertension, arteriosclerosis, enlarged heart, old myocardial infarction, coronary sclerosis, myocardial fibrosis, regular sinus rhythm	61	Yes	No	+	2 tablets t. i. d. for 3 days	131	128½	2½	3	Was practically edema free at time of administration of tablets
32. J. G.	Hypertension, enlarged heart, regular sinus rhythm	67	Yes	No	+	2 tablets t. i. d. for 2 days	136¾	132¼	4½	4	

TOXICITY

In no case, regardless of method, was there any evidence of kidney irritation. Gastrointestinal irritation as a rule was very mild and subsided promptly. In the hospitalized group 4 patients had presented nausea, vomiting or diarrhea after a single dose of 5 tablets. In 3 of these instances no diuresis was noted, and in the 4th the minimal effective diuresis occurred. In the 1 instance, patient 9, in whom the dose was repeated, although it was ineffective, it was also free of any untoward reaction. With the multiple dose method 2 instances of gastrointestinal irritation were noted. In patient 2 this could possibly have been avoided if the medication was discontinued at the second or third day. In the other instance, patient 23, the severe congestive heart failure with visceral congestion may have played a part in the symptoms.

In the ambulatory group of patients gastrointestinal irritation of minor character was noted in 6 instances. Patient 4 had anorexia and nausea, which subsided promptly within twenty-four hours and did not deter repetition of the medication when necessary. Patient 7 noted an increased frequency of bowel movements after the first trial but continued the medication for a total of 15 trials without having further evidence of gastrointestinal irritation. Patient 8 also noted increased frequency of bowel movements following 2 trials. Diarrhea was noted in the first trial in patient 10, but subsequently no untoward reactions were noted when the treatment was repeated on 9 more occasions. Patient 11 had nausea and vomiting in 2 trials out of 8. In only 1 instance, that of patient 6, who had nausea and vomiting with most drugs administered orally, was the medication discontinued.

COMMENT

The favorable influence of theophylline on the diuretic effect and toxicity of mercurial diuretics has materially altered our concept regarding their use. Although, as pointed out by DeGraff and Nadler,[6] they are not entirely free from toxic manifestations, the rarity of such occurrences explains their widespread popularity in the treatment of congestive heart failure. Several routes of administration of mercurial diuretics are available. For the patient with severe congestive heart failure necessitating rapid removal of the edema fluid, the parenteral route remains the method of choice. However, too sudden dehydration may result in two untoward sequelae of pronounced diuresis. Poll and Stern [7] have called our attention to the syndrome of hypochloremia or tissue dehydration in the presence of edema. This is noted particularly in patients with advanced arteriosclerosis or patients in chronic failure who have been on a limited diet for months or years. The second possible sequela, digitalis toxicity in patients receiving high maintenance doses of the drug, is not an uncommon observation. Attributed to the mobilization of the digitalis preparation from the edema fluid during the process of diuresis, its occurrence definitely interferes with the proper management of the patient. As emphasized previously,[3] for patients who do not require rapid removal of the edema fluid for symptomatic relief and for those who may develop the aforementioned sequelae, the oral mercurial diuretic should be the drug of choice.

6. DeGraff, A. C., and Nadler, J. E.: A Review of the Toxic Manifestations of Mercurial Diuretics in Man, J. A. M. A. **119**: 1006 (July 25) 1942.

7. Poll, Daniel, and Stern, J. E.: Untoward Effects of Diuresis, Arch. Int. Med. **58**: 1087 (Dec.) 1936.

For the hospitalized patient a single dose of 5 tablets (equivalent to 150 mg. of mercury) may be used if moderately rapid diuresis is required. Where gradual diuretic, will enhance the diuretic action. If necessary the mercurial tablets may be administered in courses three to five days apart.

TABLE 2.—*Effectiveness of Mercupurin Administered Orally in the Ambulatory Treatment of Patients with Congestive Heart Failure*

No.	Patient	Diagnosis	Age	Ammonium Chloride	Method of Administration of Mercupurin Tablets	Total No. of Trials	Results	Comment
1	N. F.	Rheumatic fever, enlarged heart, mitral stenosis, mitral insufficiency, regular sinus rhythm	39	Yes	2 t. i. d. for 2 days	2	Following first trial returned to clinic free of edema; 2d trial gave only temporary relief	Second trial was not too satisfactory because of complicating pneumonia necessitating hospitalization
2	P. L.	Hypertension, arteriosclerosis, enlarged heart, coronary sclerosis, myocardial fibrosis, regular sinus rhythm	61	Yes	2 t. i. d. for 2 days 2 t. i. d. for 3 days 2 t. i. d. for 4 days Weekly intervals	4 4 12	Good diuresis with each trial but slowly accumulated edema fluid; required mercupurin intravenously in addition at each clinic visit; previously mercupurin intravenously, weekly, was insufficient to prevent frequent attacks of paroxysmal dyspnea; since onset of tablet therapy was free of dyspnea for over five months	Patient admitted to hospital moribund following acute myocardial infarction; necropsy failed to reveal any gastrointestinal or kidney irritation
3	C. M.	Rheumatic fever, enlarged heart, mitral stenosis, mitral insufficiency, aortic insufficiency, auricular fibrillation	42	No	1 t. i. d. for 3 days at 2 week intervals	10	Good diuresis with complete removal of all edema	
4	A. N.	Syphilis, enlarged heart, aortic insufficiency, aortitis, regular sinus rhythm, cirrhosis of liver	52	No	2 t. i. d. for 2 days	2	Good diuresis with discontinuation of edema fluid; required intravenous mercupurin for complete removal of fluid	Mild anorexia and nausea for 24 hours when tablets were taken between meals
5	C. S.	Hypertension, enlarged heart, regular sinus rhythm	50	Yes	2 t. i. d. for 2 days 2 t. i. d. for 3 days	1 23	Good diuresis each time without any side reactions; prevented rapid accumulation of fluid, and clinic visits were extended from one to three week intervals; diuresis at times was equivalent to loss of 8 lbs. in edema fluid	Slow accumulation of edema necessitated use of mercupurin intravenously at each clinic visit
6	M. S.	Rheumatic fever, enlarged heart, mitral stenosis, mitral insufficiency, aortic stenosis, aortic insufficiensy, tricuspid insufficiency, tricuspid stenosis, auricular fibrillation	38	Yes	2 t. i. d. for 3 days	1	No diuresis	Nausea and vomiting
					1 t. i. d. for 2 days	1	Mild diuresis	Nausea; treatment continued with parenteral mercupurin; nausea and vomiting occurred readily with most drugs administered orally
7	N. T.	Rheumatic fever, enlarged heart, mitral stenosis, mitral insufficiency, aortic insufficiency, aortic stenosis, tricuspid insufficiency, auricular fibrillation	46	No	1 t. i. d. for 2 days at intervals of 2 to 3 weeks	5	Satisfactory diuresis on 4 occasions; delayed diuresis for 48 hours in 1 instance	Increased bowel movement but no diarrhea with one trial
					2 t. i. d. for 1 day at intervals of 1 to 3 weeks	10	Excellent diuresis with loss of 5 to 10 lbs. each trial	No toxicity; since onset of oral therapy has been free from severe failure and has not required intravenous therapy for for over 8 months
8	N. R.	Arteriosclerosis, enlarged heart, myocardial fibrosis, coronary sclerosis, auricular fibrillation	59	No	3 t. i. d. for 3 days	5	Diuresis was good with all but one trial	Slow accumulation of edema fluid necessitated intravenous mercupurin on 2 occasions; increased bowel movement, but no diarrhea following 2 trials
9	F. L.	Rheumatic fever, enlarged heart, mitral stenosis, mitral insufficiency, auricular fibrillation	..	No	2 t. i. d. for 2 days	1	No diuresis	
10	A. K.	Hypertension, enlarged heart, regular sinus rhythm	49	No	2 t. i. d. for 3 days	1	Slight diuresis	Mild diarrhea necessitating temporary cessation of medicine was first tried; further trials had no untoward reaction
				No Yes Yes	1 t. i. d. for 2 days 2 t. i. d. for 2 days 1 t. i. d. for 2 days	3 3 2	Good diuresis but insufficient to prevent slow accumulation of edema fluid	
11	G. F.	Syphilis, enlarged heart, aortic insufficiency, aortitis, dilated aorta, regular sinus rhythm	..	No	2 t. i. d. for 2 days	6	Diuresis in 4 trials	Two trials not resulting in diuresis caused nausea and vomiting
				No	1 t. i. d. for 4 days	1	Good diuresis	
				No	1 t. i. d. for 5 days	1	No effect	Patient varied in effectiveness; intravenous mercupurin at weekly intervals also ineffective to prevent reaccumulation of edema
12	L. D.	Arteriosclerosis, enlarged heart, myocardial fibrosis, auricular fibrillation	57	No	2 t. i. d. for 2 days 2 t. i. d. for 3 days	1 1	Excellent diuresis with complete removal of all signs of congestive heart failure	

removal of the edema is desired the multiple dose method of 2 tablets three times a day for two to three days has proved to be more than satisfactory. Ammonium chloride, as in the case of the parenteral mercurial

For the ambulatory patient it may be necessary to determine individually the proper dose and scheme of administration. It is advisable to begin therapy with 1 tablet taken for the first day at four hour intervals

for three doses. This may be repeated daily until diuresis is well established; the total period of administration should not exceed four days. If this dosage is insufficient, 2 tablets given according to the same method may be more effective. The patient with severe congestive heart failure may require supplementary use of the parenteral preparation at each clinic or office visit. In such a case the oral preparation should not be advised until the reaccumulated edema fluid again makes the patient uncomfortable. At the present time the daily maintenance dose of the oral mercurial diuretic is not recommended, since insufficient data are available as to the excretion and toxicity of mercury when the drug is chronically administered in this form. The use of the drug for periods of two to four days and, if necessary, repeated courses at intervals no shorter than four days has proved to be effective with a minimum of gastrointestinal irritation.

SUMMARY

In a group of 42 patients, Mercupurin tablets administered orally were found to be an effective and safe diuretic and, with proper use, are of definite value in the management of the cardiac patient with chronic congestive heart failure.

RECURRENT BULLOUS ERUPTION OF THE FEET AND HANDS (WEBER-COCKAYNE)

LOCALIZED EPIDERMOLYSIS BULLOSA

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My purpose in this paper is to report 2 instances of an unusual hereditary blistering dermatosis of the feet and hands and to call attention to its distinctive features so that differentiation from other common eruptions of the feet may be facilitated. The disease was first described by Weber [1] in 1926, who regarded it as a mild anomalous form of epidermolysis bullosa. Later Cockayne [2] examined its hereditary and familial aspects. Several reports dealing with the syndrome have appeared recently from various centers,[3] indicating that probably it is not as rare as has been supposed. Because the condition has often been diagnosed as dermatophytosis and, indeed, had been so diagnosed for each of my patients at some time in the past, these cases are presented to reemphasize the dermatologic dictum that not all blistering eruptions on the feet are caused by fungi.

I shall also describe an additional atypical case—an example of "acquired" localized epidermolysis bullosa—which does not possess heredofamilial characteristics. This form manifests all the clinical features of the inherited disease, and I have no reason to assume that the two conditions are not biologically identical. The cases of the inherited disease are presented separately solely out of deference to their remarkable genetic pattern and not because of other fundamental distinction.

1. Weber, F. P.: Recurrent Bullous Eruption on the Feet in a Child, Proc. Roy. Soc. Med. (Sect. Dermat.) **19:** 72 (June) 1926.

2. Cockayne, E. A.: Recurrent Bullous Eruption of the Feet, Brit. J. Dermat. **50:** 358-362 (July) 1938.

3. Haldane, J. B. S., and Poole, R.: A New Pedigree of Recurrent Bullous Eruption of the Feet, J. Hered. **33:** 17-18 (Jan.) 1942. Leider, M., and Baer, R. L.: Epidermolysis Bullosa Hereditaria: Report of Two Cases with Extensive Family Histories, Arch. Dermat. & Syph. **46:** 419-424 (Sept.) 1942. Mansur, H. D., Jr.: Hereditary Epidermolysis Bullosa, J. A. M. A. **120:** 1122-1124 (Dec. 5) 1942. Kierland and Harrison.[5] Frank.[6] Franks and Davis.[4]

REPORT OF CASES

CASE 1.—*History.*—A soldier aged 24, seen on June 8, 1943, gave a history of large blisters on his feet appearing for four years mostly in the summer months, especially after a great deal of walking. The blisters were painful only when he walked, and there was no pruritus or burning. The patient had noticed that since his induction into the Army, seven months before, the condition had become more severe, a circumstance which he attributed to increased walking and marching. During the month preceding his admission to the hospital he had worked as an automobile mechanic and had done relatively little walking, but the blisters nevertheless recurred. His army career had been spent exclusively at stations in Florida during warm or hot weather. While the patient was on furlough in Pennsylvania for ten days in May 1943 the eruption largely disappeared, an improvement due, the patient believed, to the cooler weather rather than to the respite from marching.

Questioning elicited the information that the patient's hands and fingers had always blistered too readily after moderate or sustained manual effort. However, there was no abnormal blistering of the skin after injury to other regions of the body. One other member of his family was affected: a 5 year old nephew, son of the patient's sister, has shown a similar abnormality of the skin of the feet since infancy, blisters occurring also during the summer months only. In both cases there was no consanguinity of the parents.

Examination.—The patient walked with some discomfort. Several thick-walled bullae, up to 1 inch (2.5 cm.) in diameter, were present on the soles, especially over the ball of each foot and immediately behind the toes. There were no calluses or scars over the soles, nor was there appreciable interdigital scaling, fissuring or maceration or evidence of either inflammation about the lesions or regional lymphadenitis. Nikolsky's sign, diminished dermal-epidermal adhesion, could not be elicited over various parts of the body. Microscopic examination of epidermis from the plantar blebs failed to disclose fungi.

Course.—After hospitalization for ten days, during which time the patient was largely confined to bed, the lesions were collapsed, dry and exfoliating. The patient was then encouraged to walk about the hospital area at will. Within two days four new bullae on each foot, averaging about ½ inch (1 cm.) in diameter, had developed on the toes and distal part of the sole. The lesions at first were flaccid, becoming tense as they increased in size. Aseptic aspiration of the bullae and a reduction of walking resulted in rapid improvement during the next few days of observation.

CASE 2.—*History.*—A soldier aged 26, admitted to the hospital Aug. 15, 1943, stated that since earliest childhood he had had recurrent blisters on his feet and to a lesser degree on his hands. His health had otherwise been excellent. He retained at all times, regardless of the amount of walking performed, at least two to four blisters on each sole. On the hands lesions would not develop unless he performed work entailing considerable manual friction and pressure. For example, moderately painful blisters would appear on his hands and fingers if he raked a lawn or if he gripped the steering wheel of a vehicle tightly while driving, even though he wore gloves during both operations. Trauma of other parts, such as the shins, caused the skin to become denuded easily ("barked"), but blisters would not result.

There was no consanguinity of the parents. The paternal grandmother had had the same disease. The patient's father during his youth had also suffered recurrent blisters on his soles, but in a mild form and only after activities such as dancing or strenuous walking; apparently there has been no similar trouble in later life. A representation of the familial incidence of the disease is given in figure 1.

Examination.—Small bullae, each with a violaceous halo, were present on the volar aspect of the left third and fourth fingers (fig. 2 *a*). Large thick-walled bullae occupied the dorsa of the toes and the weight bearing parts of the toes and soles, and one large bulla occurred on the lateral surface of the left heel (fig. 2 *b*). There were no scars or calluses. Microscopic examination of epidermis from the lesions disclosed no fungi.

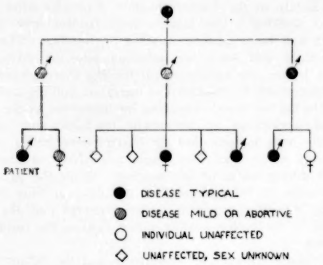

Fig. 1.—Pedigree of patient 2 with recurrent bullous eruption of feet and hands, illustrating the dominant hereditary transmission of the defect.

A small area of the volar surface of the right forearm was traumatized by rubbing vigorously with a blunt metal instrument. Shortly afterward the skin became reddened and puffy, and within three hours a small vesicle appeared in its center. The reaction persisted for twenty-four hours. A biopsy of unaffected skin from the forearm in the proximity of the induced vesicle failed to reveal abnormality of any of its structures, including the elastic tissue.

Course.—A recent communication from the patient reports that bullae have become more frequent on the hands, probably because of his work, which consists of handling parcels. He does little walking, but, as usual, bullae still recur on his feet.

The following case lacks the qualities of onset in childhood and familial background displayed in the 2 previous cases. The recurrent blebs, singularly limited to the fifth toes, constitute so peculiar and definite a syndrome that I am at a loss to classify it in any category other than the present one. This case and 1 recorded by Franks and Davis [4] will serve as a basis for the hypothesis that variants of localized epidermolysis bullosa may be of tardy development and not necessarily familial or hereditary.

Case 3.—*History.*—An officer aged 23 years acquired single, slightly tender, recurrent blisters on the plantar aspect of each small toe during the spring of 1942, within one month after his induction into the Army. Usually the blister would rupture several days after its appearance, and a new one would arise at the identical spot within a few days or several weeks. In the winter of 1942-1943 there had been little trouble with the lesions, but in March 1943 they reappeared and recurred continuously.

Blisters had never appeared elsewhere on his feet or on his hands, nor had any member of his family been known to have a similar disease. Abundant well managed fungicidal treatment had in the past been of no avail in stemming the eruption. He had tried wearing open toe sandals and lamb's wool wrapping about the affected toes, and he had had shoes fitted under the personal supervision of a competent orthopedist, all without benefit.

Examination.—The following observations have been made on numerous occasions since May 1943: The lesions are symmetrically placed near the tip of each fifth toe, at the apex of the pyramid formed by the plantar, inferomedial and medial surfaces of the toe (fig. 3). A flaccid bleb arises with thick walls, and the surrounding epidermis is thickened, spongy and macerated. Hyperhidrosis of the feet is present to a moderate degree, but there is no interdigital scaling suggestive of dermatophytosis. Repeated microscopic examination of epidermal material and cultures on Sabouraud's medium have failed to disclose evidence of fungi in the affected skin.

Course.—In November 1943 the patient was confined to the hospital for one week at rest in bed, during which time the lesions healed. He then resumed walking, but within the next few weeks he was unable to cause the bullae to reappear in spite of long walks in heavy shoes. He ascribed his improvement to the cooler weather, as it duplicated his experience of the previous year. With the advent of hot weather in February 1944 identical bullae again formed on the toes.

Admittedly, further observation of my third patient would be desirable before the diagnosis of epidermolysis bullosa could be unequivocally accepted. Against this criticism my defense is that many diagnostic possibilities were carefully considered in studying the case and then were one by one discarded as inadequate, until by elimination epidermolysis bullosa stood alone as the sole acceptable classification for the disorder.[5]

DIFFERENTIAL DIAGNOSIS

The bullae in the disease under consideration are often large, up to 1 inch diameter or larger. Such huge bullae are not characteristic of ordinary forms of dermatophytosis, in which the vesicles are generally of pea size or

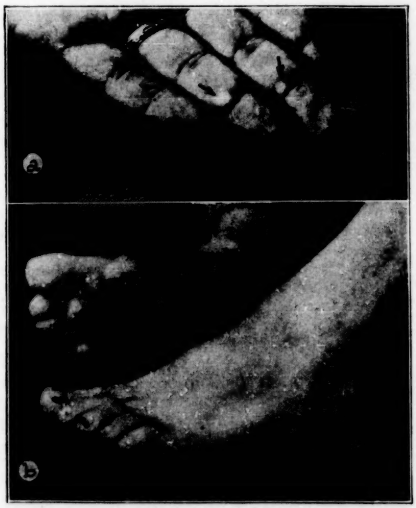

Fig. 2.—Recurrent bullous eruption (case 2) showing (*a*) two small blebs on fingers and (*b*) large blebs on toes, right sole and lateral aspect of left heel.

smaller. It is, of course, true that giant bullae may emerge exceptionally in cases of dermatophytosis and also of dermatophytid, and this circumstance may lead in the absence of other data to confusion with epidermolysis bullosa. Both the fungous infection and epidermolysis

4. Franks, A. G., and Davis, M. I. J.: Epidermolysis Bullosa, Arch. Dermat. & Syph. **47**: 647-659 (May) 1943.

5. Capt. Reuben M. Reifler, M. C., A. U. S., has informed me that recently he observed a similar case with onset in adult life, the bullae occurring exclusively on the great toes.

bullosa exhibit in common the tendency to exacerbation during hot weather. If pruritus is a symptom, it will suggest dermatophytosis. A history of recurrent lesions since childhood is practically pathognomonic of epidermolysis bullosa, because dermatophytosis of the feet in children is distinctly rare. Direct microscopic search of the skin for fungi is essential in any doubtful case and

Fig. 3.—Recurrent bulla of tip of fifth toe (case 3). The dark crust was produced by the application of solution of silver nitrate.

constitutes a simple expedient for establishing a diagnosis.

Large traumatic blebs, from friction of improperly fitting shoes and socks and from excessive walking, normally heal in time; or, if walking is continued, the skin of the feet becomes "toughened" or calloused in consequence of the repeated insult. Not such is the case, however, with epidermolysis bullosa, in which the epidermal reaction is not the physiologic one of thickening for protection but is rather a passive yielding to the pressure of fluid exuded beneath it, and this process is repeated over and over again. There is no scarring, callus formation or other residuum of the bullae.

Contact dermatitis of the feet due to sensitization to shoe leather or dyes may lead occasionally to the formation of huge bullae, but they are nearly always confined to the sides or dorsa of the feet and toes, where the skin is relatively thin, and especially over the great toes. The thick corneous covering of the soles constitutes an important barrier to irritant chemical agents, and contact eruptions of the plantar surfaces are therefore either imperceptible or much less severe than eruptions over the dorsa of the feet. Also epidermolysis bullosa is primarily a noninflammatory disease, and its bleb is initially unattended by signs of erythema. This is in distinction to contact dermatitis, in which erythema is one of the earliest visible phenomena induced by the offending material and vesiculation is associated with pruritus and other eczematous accompaniments, such as edema, scaling, exudation, crusting and excoriations.

Bullous drug eruptions, plantar and palmar eruptions of congenital syphilis and bullous scabies in infants may be mentioned without further comment as other conditions which might rarely be considered in the differential diagnosis.

COMMENT

In epidermolysis bullosa an inherent vulnerability of the skin leads to the formation of blebs over a part subjected to mechanical trauma. Classically the skin over the entire body, or most of it, partakes of this predisposition, and in some cases permanent scarring results. For the variant described by Weber and Cockayne, however, the abnormality is localized to a great extent, so that in general the feet manifest the lesions preponderantly and in many cases even exclusively. Appearing first during infancy or earliest childhood, the bullae apparently represent an exaggeration of the normal tendency of the skin to blister as a response to physical irritation. When blebs appear on the hands in localized epidermolysis bullosa they are usually not so prominent nor so abundant as those on the feet. A few transient lesions elsewhere than on the feet and hands are occasionally observed. Such instances, I believe, constitute transitions between the strictly localized forms of the disease on the feet and the classic, generalized, inordinately blistered forms presented in the cases of the textbooks.

Most authors have recorded failure to produce fresh lesions in their patients by rubbing the skin. Frank [6] found that in his patient bullae developed after vigorous rubbing over the sides of the feet but not on other areas, including the plantar surfaces. In my case 2 there was a latent tendency for blister formation over the normal cutaneous surface, as indicated by the vesicular reaction elicited on rubbing a region of the skin which had never spontaneously blistered. Weber [1] originally suggested that irritation of the feet in moist socks during warm weather might account for the eruption rather than trauma alone. Cockayne [2] decided that the exciting cause for the formation of bullae in this disease is probably a combination of pressure and moisture. Of interest is the exacerbation of lesions during hot weather, a seasonal variation consistently manifested by the majority of patients (and known often to occur as well in the generalized forms of epidermolysis bullosa). The skin is not abnormally reactive to thermal applications, however. What role pathologic porphyrin metabolism may play in this process is deserving of further investigation.[7]

Usually the patients report multiple familial cases of localized epidermolysis bullosa affecting several generations. However, there are also solitary, presumably nonfamilial cases on record.[8] It is conceivable that the disease in the occasional patient who can furnish no information indicating a hereditary influence may actually have had its genetic inception as a mutation. My third case, presented as an acquired form of the eruption, is therefore remarkable not because it lacks hereditary background but because of its origin in adult life.[9] Comparable circumstances of atypical development in later life are not, however, unprecedented among other, more familiar, hereditary diseases. It will be noted also that the first patient did not exhibit lesions on his feet until the age of 20, although his hands had been affected since childhood, which indicates a local tardiness in development of the syndrome. There is no doubt that the strenuous conditions of military life may cause to become manifest an otherwise latent inherent vulnerability of the skin; to this fact I ascribe the onset of the disease in my third patient shortly after his induction into the Army.

In a case of epidermolysis bullosa reported recently by Dean [10] lesions limited to the hands and fingers and

6. Frank, S. B.: An Unusual Variant of Epidermolysis Bullosa: Recurrent Bullous Eruption of the Feet, Arch. Dermat. & Syph. **47**: 327-334 (March) 1943.

7. Kierland, R. R., and Harrison, M. W.: Epidermolysis Bullosa with Unusual Distribution and Elevated Urinary Porphyrins: Report of a Case, Proc. Staff Meet., Mayo Clin. **15**: 313-316 (May 15) 1940.

8. Weber,[1] Kierland and Harrison.[7]

9. Hundley, J. L., and Smith, D. C.: Epidermolysis Bullosa Acquisita, South. M. J. **34**: 364-370 (April) 1941.

10. Dean, D. M.: A Case of Epidermolysis Bullosa Hereditaria, J. Roy. Navy M. Serv. **27**: 74-79 (Jan.) 1941.

with distinct familial transmission were exhibited. This might be regarded as an analogous form of strictly regional epidermolysis bullosa. But the scarring produced by the lesions, the deformed finger nails and the imperfect dental development all combine to classify the case as one of localized "dystrophic" epidermolysis bullosa.

In contrast to this the "simple" type of epidermolysis bullosa, of which the recurrent bullous eruptions of Weber and Cockayne seem to be a subgroup, never produces abnormal sequelae in the skin, and the cutaneous appendages are invariably normal.

SUMMARY AND CONCLUSIONS

Cases of a recurrent blistering eruption of the feet and hands with dominant heredity, comprising a characteristic localized form of epidermolysis bullosa, were observed. The bullous lesions are preceded by mild grades of local friction, pressure, heat and moisture. One of the cases reported is unique because of strict limitation of the lesions to the fifth toes, onset in the third decade of life and absence of other familial cases; but examination of the literature indicates that failure to demonstrate a hereditary basis does not preclude classification in this category. The question of whether the boundaries of the syndrome should be defined by the hereditary or by the topographic features cannot be decisively answered. I favor the latter criterion, for it is my impression that the disease is the same, with or without familial background. But in the former group the dominant heredity is so striking a characteristic that these cases are deserving of the special recognition first accorded to them by Cockayne. There are apparently gradations of severity of the syndrome, which in the cases of more extensive involvement probably span the transition between purely localized forms and generalized epidermolysis bullosa.

The strenuous physical demands of military life may be conducive to activation of a latent blistering tendency, or they may exacerbate a previously mild form of the disease to the point of temporary disablement. The diagnosis in most cases is established by the family history, onset in childhood and relationship to excessive walking or manual work. Diagnostically the disease seems most frequently to be confused with dermatophytosis of the feet, from which it may be distinguished by the foregoing features and by a carefully conducted mycologic examination of the affected skin. Probably localized epidermolysis bullosa is not as uncommon a disorder as has been hitherto believed.

Psychologic Disturbances Among Children.—The general belief is that there has been no great increase in psychologic disturbances among children in the countries at war and that the majority of those that exhibited them presented problems also before the war. Analysis of the behavior problems indicates that in 10 per cent of the cases the foster home was unsuitable; in 19 per cent the parents of the child were the disturbing factor and, in the rest, the difficulty was due to some preexistent personality or intellectual anomaly. Disorganization of the child's regular routine is a very devastating factor. Rest, sleep, food, warmth are important physical requisites, while amusements are indispensable for morale. Favorable psychological conditions should take into consideration the social status of the children and provide for billets of about the same social level.—Davis, John E.: Principles and Practice of Rehabilitation, New York, A. S. Barnes & Co., Inc., 1943.

ERYTHROCYTE DAMAGE BY LIPEMIC SERUM IN NORMAL MAN AND IN PERNICIOUS ANEMIA

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Describing the absorption of the products of fat digestion into the lymphatic system instead of into the intestinal blood capillaries, A. P. Mathews [1] wondered "why the fat should thus be passed into the blood by going . . . through the thoracic duct" and ventured the prediction that "there is very little doubt that some good reason exists for this peculiar arrangement." The following experiments conducted by us and other collaborators at the University of Chicago have partially provided the "good reason."

Lacteal lymph collected close to the small intestine in dogs after a fatty meal is strongly hemolytic.[2] Some free fatty acids and soaps, which apparently escape resynthesis into neutral fat during the absorption of the digestion products of fat, are demonstrable in chyle in quantities sufficient to account for this hemolysis.[3] By the time the chyle reaches the subclavian vein these hemolytic agents are decreased in concentration, probably largely because thoracic duct chyle is diluted by lymph from parts of the body other than the intestine.[2]

The following safeguards appear to protect against hemolytic fatty acid or soap entering the blood stream too rapidly or in too great amounts: [4] A high fat meal tends to cause vomiting; the emptying time of the stomach is longer after a fat meal than after meals rich in carbohydrate or protein; during absorption most of the injurious fatty acids and soaps are resynthesized into harmless neutral fat; the unresynthesized hemolytic substances entering the lacteals are diluted in the thoracic duct, and they enter the blood stream slowly and mix in the subclavian vein and the heart with blood from all the body instead of mixing initially with only the blood in the intestinal capillaries.

Despite these protective mechanisms, after a fat meal the circulating red blood cells become exposed to a sufficient quantity of the hemolytic agents to increase the rate of normal daily red cell destruction. In dogs,[5] and also (as shown in another laboratory) in human infants,[6] the daily excretion of the degradation products of hemoglobin is greater on a high than on a low fat diet. Also dogs' red blood cells exposed to lipemic

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This work was aided in part by a grant from the Dr. Wallace C. and Clara A. Abbott Memorial Fund of the University of Chicago.

The cooperation of Drs. R. W. Keeton and L. R. Limarzi of the Illinois Research Hospital of the University of Illinois, and of Drs. Gurth Carpenter and Leon Jacobson of the Billings Memorial Hospital of the University of Chicago, in securing patients for this study, is greatly appreciated.

1. Mathews, A. P.: Physiological Chemistry, ed. 3, New York, William Wood & Co., 1920, p. 452.

2. Johnson, V., and Freeman, L. W.: The Adaptive Value of Absorption of Fats into the Lymphatics, Am. J. Physiol. **124**: 466 (Nov.) 1938.

3. Freeman, L. W., and Johnson, V.: The Hemolytic Action of Chyle, Am. J. Physiol. **130**: 723 (Oct.) 1940.

4. Longini, J., and Johnson, V.: Increased Red Blood Cell Fragility After Fat Ingestion, Am. J. Physiol. **140**: 349 (Dec.) 1943. Johnson and Freeman.[3]

5. Freeman, L. W.; Loewy, A.; Marchello, A., and Johnson, V.: Increased Total Bile Pigment Output on a High Fat Diet, Federation Proc. **1**: 25 (March) 1942. Loewy, Freeman, Marchello and Johnson.[13]

6. Josephs, H. W.; Holt, L. E.; Tidwell, H. C., and Kajdi, C.: Influence of Fat upon the Excretion of Urobilin, J. Clin. Investigation **17**: 532 (July) 1938. Josephs, H. W.; Holt, L. E.; Tidwell, H. C., and Kajdi, C.: The Influence of Dietary Fat upon the Excretion of Urobilin, Bull. Johns Hopkins Hosp. **71**: 84 (Aug.) 1942.

serum in vitro are immediately rendered more fragile.[7] These experiments suggest that red cells are destroyed in vivo very soon after the products of fat digestion enter the blood stream. Actually there is an increased bilirubin excretion in anesthetized dogs within an hour or two after intravenous injection of small quantities of fatty acid or soap.[8]

In most of these experiments on red blood cells, rather large quantities of fat (5 to 10 Gm. per kilogram of body weight) were fed. The question remained whether the ingestion of fat in quantities more nearly physiologic would produce similar damage to red blood cells. Also the extent to which the findings on dogs might be applicable to man remained to be determined.

ERYTHROCYTE FRAGILITY IN NORMAL MAN

In experiments on normal human subjects a breakfast of 1 pint of 32 per cent whipping cream (about 150 Gm. of fat) was given in each experiment. A fasting blood sample was drawn at the time of the meal; some of this was oxalated, providing red blood cells for the experiment, and the rest was allowed to clot and was centrifuged, providing a sample of fasting serum. Blood drawn at two hours and at three and one-half or four and one-half hours after the fat meal provided samples of lipemic serum. The following mixtures were made in duplicate: (A) one volume of red cells (oxalated blood) plus one volume of fasting serum (mixed for two hours) plus 2 volumes of distilled water (mixed for thirty minutes) and (B) an identical mixture except that lipemic serum was employed instead of the fasting serum of mixture A. Red blood cell counts were then made on each mixture in quadruplicate. This procedure constituted a fragility test in which susceptibility to hypotonic hemolysis was compared for red blood cells exposed to fasting serum and red blood cells exposed to lipemic serum. In a few of the experiments, besides the addition of water and performance of the fragility test described, equal quantities of powdered sodium oleate were dissolved in the fasting control and the lipemic serum samples.

The results are plotted in chart 1. All "control counts" on mixture A (red cells plus fasting serum) are arbitrarily placed at 100 per cent. "Test counts" on mixture B (red cells plus lipemic serum) are plotted as percentages of the control count. Inspection of chart 1 shows that in general the test counts are lower than the control counts, indicating that exposure of normal human red blood cells to lipemic serum renders those cells more susceptible to hemolysis by distilled water or by soap solutions. Chance variations or experimental error should produce a symmetrical pattern of columns centered at 100 per cent. Statistical analysis of the results of 111 pairs of observations on 27 subjects reveals that the counts on red cells exposed to lipemic serum are significantly lower than the counts on red cells exposed to fasting serum, even though the average of all test counts is only about 6 per cent below the control counts.

Forty-eight additional pairs of observations were made on 17 normal human subjects who drank 150 Gm. of corn oil instead of whipping cream. The results (not included in chart 1) similarly showed a significant erythrocyte-damaging effect of lipemic serum.

7. Longini, J.; Freeman, L. W., and Johnson, V.: Increased Red Blood Cell Fragility During Lipemia, Federation Proc. **1**: 51 (March) 1942. Longini and Johnson.[4]

8. Freeman, L. W.; Loewy, A., and Johnson, V.: In Vivo-Hemolysis Produced by Soap Injection, Am. J. Physiol. **140**: 556 (Jan.) 1944.

ERYTHROCYTE DAMAGE IN PERNICIOUS ANEMIA

The experiments cited and here reported indicate that an appreciable part of the daily destruction of red blood cells in normal man may be attributed to the injurious effects of fat ingestion, although the normal bone marrow seems fully able to compensate for these red cell losses. However, it seems possible that an increase in this destructive effect of ingested fat might be responsible for certain human anemias. Experiments were performed on pernicious anemia, comparing the hemolytic effect of lipemic serum on red cells in 8 cases of untreated pernicious anemia, 6 cases of adequately treated pernicious anemia and 7 normal individuals. In each experiment a fasting blood sample was drawn. A portion of this was heparinized, providing cells for the experiment; the remainder was allowed to clot, providing fasting serum. A pint of 32 per cent cream was given, and in three to four hours another blood sample was drawn to provide lipemic serum. The following mixtures were made in duplicate: (A) one volume of cells (heparinized blood) plus one volume of fasting serum and (B) one volume of cells (heparinized blood) plus one volume of lipemic serum. The paired mixtures were shaken for two minutes and in some instances were kept at 5 C. for sixteen hours. Quadruplicate red cell counts were then made on each mixture. It is noteworthy that these were not fragility tests but measurements of direct hemolytic action of lipemic serum on red cells.

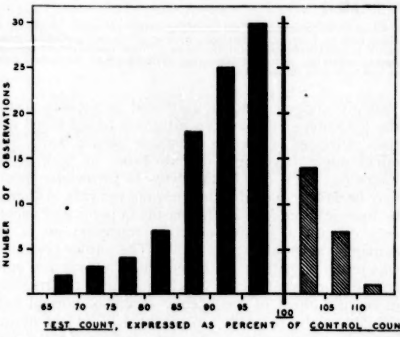

Chart 1.—Results of 111 pairs of observations on the susceptibility of red blood cells of 27 normal human subjects to damage by lipemic serum. "Control counts" are the red blood cell counts (considered as 100 per cent in each of 111 observations) on one volume of centrifuged oxalated blood plus one volume of fasting serum (mixed for two hours) plus two volumes of distilled water (mixed for thirty minutes). "Test counts" are the red blood cell counts (usually less than 100 per cent) on the same mixture except that lipemic serum replaced fasting serum. Black columns, 89 observations showing decreases in counts after exposure of red cells to lipemic serum. Cross hatched columns, 22 observations showing somewhat higher counts after exposure of red cells to lipemic serum. Chance variations or experimental error should produce a symmetrical pattern of columns centered at 100 per cent.

The results are plotted in chart 2. Each erythrocyte count on red blood cells mixed with lipemic serum (test count) is expressed as a percentage deviation from the count on red cells from the same blood sample mixed with fasting serum (control count). In normal and treated pernicious anemia subjects the test counts (on cells plus lipemic serum) ranged from 5 per cent more than the control counts (on cells plus fasting serum) to 6 per cent less than the control counts. This range approximates the limits of accuracy of the experimental procedure. By contrast, the test counts on the 8

untreated pernicious anemia cases were from 4 to 17 per cent lower than the control counts, indicating that exposure of such cells to lipemic serum destroyed from 4 to 17 per cent (average nearly 9 per cent) of the cells.

Although too few in number to analyze statistically or to warrant final conclusions, these experiments

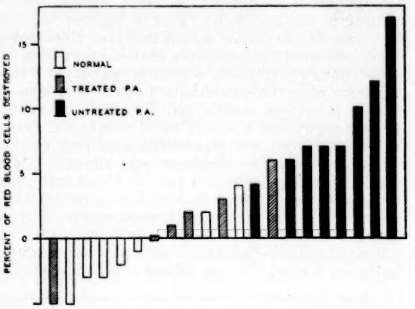

Chart 2.—Comparison of the hemolytic action of lipemic serum on red blood cells in 7 normal individuals, 6 cases of treated pernicious anemia and 8 cases of untreated pernicious anemia. Test counts on red cells plus lipemic serum are plotted as percentage deviations from the control counts on red cells plus fasting serum.

strongly suggest that in untreated pernicious anemia the ingestion of fat is more injurious to red blood cells than in treated pernicious anemia or normal man. This effect might have been due to either or both of the following: (1) The erythrocytes in pernicious anemia may be more susceptible than normal red cells to damage by lipemic serum or (2) the plasma in pernicious anemia may contain a greater effective concentration of the damaging agent after a fat meal. The former possibility was tested on patients with pernicious anemia and other anemias, in experiments which compared the fragility-increasing effect of the lipemic serum of normal individuals on the red cells (in oxalated blood) of normal and anemic subjects. For each experiment the four mixtures presented in the table were made in duplicate,

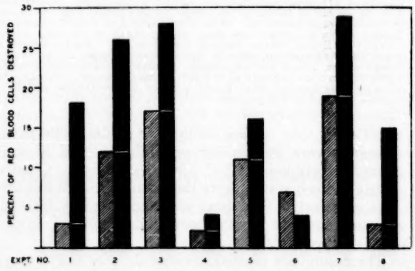

Chart 3.—Comparison of increased red blood cell fragility (produced by exposing the cells to normal lipemic blood plasma) in normal men and in untreated pernicious ane.....a. Cross hatched, destruction (in a standard fragility test) of normal red blood cells on exposure to normal lipemic serum. Black, destruction of red blood cells of untreated pernicious anemia patients on exposure to same sample of normal lipemic serum.

employing one volume of each component. Each mixture was shaken for two hours, two volumes of distilled water were added, shaking was resumed for thirty minutes, and finally quadruplicate erythrocyte counts were made.

Sixty sets of observations were made on 12 anemic patients, 7 with anemias other than pernicious anemia and 5 with pernicious anemia adequately controlled with liver therapy. In these cases the fragility of the cells was increased by exposure to normal lipemic serum, but this increase was no greater than that produced by the same lipemic serum on the cells of normal subjects.

By contrast, 2 patients with pernicious anemia who had not been receiving specific therapy gave the results plotted in chart 3. Eight sets of observations were made on these patients. In each experiment lipemic plasma from a normal individual increased the fragility of the red cells of the normal control. But in 7 of the 8 observations that same lipemic plasma from a normal man had a greater fragility-increasing effect on the red cells in untreated pernicious anemia. In five experiments the effects were striking.

These observations strongly suggest that the ingestion of fat may injure the red cells sufficiently to contribute significantly to the anemia, and that an abnormal sensitivity of the red cells to the products of fat absorption may be an etiologic factor in pernicious anemia.

CONCENTRATION OF FATTY HEMOLYSIN IN LIPEMIC SERUM

Besides this increased erythrocyte sensitivity to the products of fat digestion, it is also possible that pernicious anemia might be related to the development of an abnormally high plasma concentration of erythrocyte-damaging material following fat ingestion. Evidence for this could come either from chemical analyses

Mixtures Employed

Mixture number.....	1	2	3	4
Oxalated whole blood (red cells) of	Normal subject	Normal subject	Anemic case	Anemic case
Serum of normal individual	Fasting	Lipemic	Fasting	Lipemic

of lipemic serums for fatty acid and soap content or from experiments testing the fragility-increasing effect on red blood cells produced by pernicious anemia lipemic serum as compared with normal lipemic serum. Such experiments have not yet been carried out.

Prolonged feeding of a high fat diet in animals would appear to be the simplest way to effect such a condition experimentally. Rabbits, guinea pigs and rats were given large quantities of fat in the diet or by stomach tube for three to eight weeks. Occasionally there were transitory depressions of the red blood cell count, but no real anemia developed, although there are reports of production of anemia in animals from the administration of fatty acids [9] and fats.[10] Dogs [11] and human infants [6] administered a sufficiently high fat diet to increase the bile pigment excretion also failed to develop an anemia. In general, normal animals seem able to compensate for plasma increases in fatty erythrocyte-damaging substances probably mainly by increasing the rate of production of red blood cells but perhaps also by neutralizing these hemolysins in the blood stream.

In one series of experiments in this laboratory the blood pictures of dogs maintained on a high fat diet

9. Faust, E. S.: Ueber chronische Ölsäurvergiftung, Arch. f. exper. Path. u. Pharmakol. (supp.) **59:** 171 (Oct.) 1908.

10. Adler, H. M.: The Experimental Production of Pernicious Anemia in Rabbits, J. M. Research **28:** 199 (May) 1913.

11. Loewy, A.; Freeman, L. W.; Marchello, A., and Johnson, V.: Increased Erythrocyte Destruction on a High Fat Diet, Am. J. Physiol. **138:** 230 (Jan.) 1943.

for several months were compared with those of dogs on a low fat diet.[12] A secondary anemia was maintained in all animals by repeated bleedings. Recovery from the anemia was approximately as rapid and as complete in the dogs on a high fat diet as it was in the dogs on a low fat diet. However, autopsy revealed a greater amount of active hemopoietic tissue in the bone marrows of the fat-fed dogs. This indicates that, although recovery from hemorrhage was not appreciably impaired by a high fat diet, the bone marrow of fat-fed animals was taxed more than the marrow of anemic dogs fed a low fat diet.

Attempts were also made to drive the products of fat digestion directly into the blood capillaries of the intestine so that injurious agents would mix with the relatively small quantities of blood flowing through the intestinal capillaries instead of being diluted in the thoracic duct and slowly mixing in the subclavian vein with large quantities of blood. The results were inconclusive. Ligation of all visible intestinal lymph vessels in dogs under anesthesia and subsequent feeding of high fat diets produced no anemia. Autopsies revealed regeneration and anastomoses of lymphatics across the points of ligation within two to four weeks. In another series of observations on dogs, infusion of thoracic duct chyle into small intestinal arteries, so that chyle and blood were mixed in the intestinal capillaries, yielded inconsistent results on the rate of bile pigment excretion in acute experiments.

BLOOD DESTRUCTION IN PERNICIOUS ANEMIA

These experiments lend support to the concept that hemolysis is at least a factor in pernicious anemia. The findings of bilirubinemia, greatly increased bile pigment excretion and the high iron content of the serum, liver, spleen and kidney, ordinarily identifying "hemolytic anemias," appear in pernicious anemia. Whipple[13] sought to reconcile such findings with the maturation-arrest theory by assuming that hemoglobin or its precursors are formed extracellularly and are split to bile pigments in the absence of mature erythrocytes to take them up. However, direct evidence on this point is lacking.

In this connection Dobriner and Rhoads[14] refer to experiments on iron-deficiency anemias. In these anemias, since injected iron is recovered almost quantitatively as hemoglobin, there is no reason to assume a defect in the synthesis of protoporphyrin. If protoporphyrin can be converted directly to bile pigment without having been incorporated into red cells, one would expect to find a normal bile pigment output in these conditions. However, the pigment excretion is actually reduced sharply.

In reviewing the evidence against the maturation-arrest hypothesis, Dock,[15] and Dobriner and Rhoads[14] point out that the bone marrow picture in pernicious anemia differs in no essential respect from the pictures in certain anemias not caused by bone marrow defects, including hemolytic icterus, experimental saponin anemia and experimental hemorrhagic anemia. It is also pertinent that coproporphrin I excretion, an index of bone marrow activity, increases in relapse in pernicious anemia and decreases appreciably on liver therapy just as it does in hemolytic icterus following splenectomy.[14]

Bile pigment excretion in pernicious anemia has been demonstrated definitely to decrease on liver treatment. This response appears during the reticulocyte shower.[16] Minot and Murphy[17] had previously noted that the serum jaundice cleared up before the reticulocyte shower.

In vitro studies on blood in pernicious anemia have contributed further support to the hemolytic theory. Horrall and Buchman[18] showed the serum to be hemolytic. Ponder and Rhoads[19] found the red cells in pernicious anemia to be less resistant than those of normal individuals to hemolysis by saponin or bile salts. In the light of the work of the Chicago investigators, emphasizing the role of absorbed fatty acids in erythrocyte destruction, it is especially significant that Zinch, Clark and Evans[20] reported that the serum of pernicious anemia patients counteracts hemolysis by sodium oleate (and also by saponin) less efficiently than normal serum. Our results plotted in chart 3 may have been partially due to this very effect, because in testing the fragility of untreated pernicious anemia red cells some of the patients' plasma remained with the cells tested. However, that plasma was diluted by approximately double its volume of normal plasma in carrying out the experiments.

Evidence is accumulating that liver extract acts in anemias generally by protecting the erythrocytes from excess hemolysis. Liver has been demonstrated to protect red cells against saponin hemolysis[21] and also to be curative in the anemia produced by indole plus a deficient diet.[22] It is not absolutely established that the latter is entirely a hemolytic anemia, but indole alone is known to increase red cell destruction.[23]

These persistent ideas that pathologic hemolysis is a factor in pernicious anemia and that therapy is probably effective because it is antihemolytic are supported by our experimental evidence that fat ingestion injures red blood cells in untreated pernicious anemia more than in normal individuals or in treated pernicious anemia. A new significance is lent the incidental observation of Minot and Murphy[17] that ". . . it seemed to us . . . that decreasing the amount of fat in the diet of the pernicious anemia patient might have a favorable effect on the state of the blood."

The evidence presented in this paper would seem to provide a basis for attempts to control or improve pernicious anemia by a diet as nearly fat free as possible.

SUMMARY AND CONCLUSIONS

1. There are several mechanisms protecting against exposure of erythrocytes to too high concentrations of injurious fatty acids and soaps. These include absorption of the products of digested fat into the lymphatics,

12. Dupee, C.; Johnson, V.; Marchello, A.; Wilner, W., and Freeman, L. W.: Stimulation of the Red Bone Marrow by Fat Ingestion in Anemic Dogs. Federation Proc., 1944, to be published.

13. Whipple, G. H.: Hemoglobin Construction Within the Body as Influenced by Diet Factors: A Consideration of Anemia Problems, Am. J. M. Sc. **175:** 721 (June) 1928.

14. Dobriner, K., and Rhoads, C. P.: Metabolism of Blood Pigments in Pernicious Anemia, J. Clin. Investigation **17:** 95 (Jan.) 1938.

15. Dock, W.: The Importance of Hemolysis in the Pathogenesis of Macrocytic Anemia, in Medical Papers Dedicated to Henry Asbury Christian, Baltimore, Waverly Press, 1936, p. 545; The Ebb and Flow of the Theories About Pernicious Anemia, Am. J. Clin. Path. **8:** 620 (Nov.) 1938.

16. Farquharson, R. F.; Borsook, H., and Goulding, A. M.: Pigment Metabolism and Destruction in Addison's (Pernicious) Anemia, Arch. Int. Med. **48:** 1156 (Dec.) 1931.

17. Minot, G. R., and Murphy, W. P.: Treatment of Pernicious Anemia by a Special Diet, J. A. M. A. **87:** 470 (Aug. 1) 1926.

18. Horrall, O. H., and Buchman, T. E.: Hemocidal Properties of the Blood Serum with Special Reference to Pernicious Anemia, Arch. Int. Med. **41:** 482 (April) 1928.

19. Ponder, E., and Rhoads, C. P.: Red Cell Resistance to Lysins in Pernicious Anemia, Proc. Soc. Exper. Biol. & Med. **38:** 540 (May) 1938.

20. Zinch, R. H.; Clark, H. M., and Evans, F. A.: The Protective Power of Serum in Pernicious Anemia and Other Conditions Against Hemolysis by Saponin and by Sodium Oleate, Bull. Johns Hopkins Hosp. **33:** 16 (Jan.) 1922.

21. Paschkis, K., and Taylor, G.: Ueber die Wirkung des antianämischen Leberstoffes bei toxischen Experimentalanämien, Klin. Wchnschr. **13:** 1538 (Oct. 27) 1934.

22. Rhoads, C. P.: Effect of Indole on Hemopoiesis in Dogs Fed Deficient Diets, Proc. Soc. Exper. Biol. & Med. **38:** 652 (June) 1937.

23. Rhoads, C. P., and Barker, W. H.: The Hemolytic Effect of Indol in Dogs Fed Normal Diets, J. Exper. Med. **67:** 267 (Feb.) 1938.

dilution of hemolysin in the thoracic duct, a slow emptying of chyle into the blood, and mixing of hemolytic chyle with large volumes of blood in the subclavian vein and heart.

2. The erythrocytes of normal man are rendered more susceptible to hypotonic hemolysis (in a standard fragility test) by exposure to lipemic serum. This constitutes further evidence that fat ingestion is one factor in the normal daily destruction of red blood cells.

3. A high fat diet in normal animals does not cause a sufficiently great increase in daily erythrocyte destruction to produce anemia. The normal bone marrow is capable of replacing these extra losses of red blood cells.

4. In untreated pernicious anemia, lipemic serum produced not only an increased erythrocyte fragility but also actual hemolysis, when lipemic serum and red cells of the same individual were mixed. By contrast, lipemic serum of adequately treated pernicious anemia patients and of normal man produced only increased fragility but no actual hemolysis of their own red blood cells.

5. On exposure to lipemic serum of a normal man, the erythrocytes of pernicious anemia patients were rendered more susceptible to hypotonic hemolysis (as revealed by a standard fragility test) than were the red cells in normal individuals, certain anemias other than pernicious anemia, and treated pernicious anemia.

6. An excessive destruction of erythrocytes by the digestion products of fat is probably one of the etiologic factors in pernicious anemia, because of a more than normal sensitivity of pernicious anemia red blood cells to such products. A deficient plasma protection against these materials may also be involved.

Clinical Notes, Suggestions and New Instruments

INFECTIOUS MONONUCLEOSIS IN THE NEGRO

REPORT OF TWO CASES IN CHILDREN

ROSWELL D. JOHNSON, M.D., NEW HAVEN, CONN.

Since it has been stated in recent publications [1] that infectious mononucleosis affecting the Negro is limited to 1 case,[2] the occurrence of the disease in 2 Negro children in this clinic is of sufficient interest to warrant publication.

REPORT OF CASES

CASE 1.—*History.*—F. N., a 10 year old Negro boy, had one elder normal sibling. On the fourth day of life the patient acquired an intertriginous skin rash, and the Wassermann reaction of the blood on this day and two weeks later was positive (4 plus) with cholesterol antigen and negative with alcoholic antigen; the Kahn reaction of the blood was 2 plus. The tests were repeated at 2½, 6, 9 and 16 months, with negative reactions. The Kahn reaction of the mother's blood is not recorded. Roentgenograms of the long bones at 14 days of age showed no changes suggestive of congenital syphilis. Aside from these data, the past history was noncontributory.

Present Illness.—Twenty-four hours previous to his admission to the hospital the boy began to complain of sore throat, and because of inadequate home care he was admitted to the pediatric service on Sept. 27, 1941.

Physical Examination.—The temperature was 38.2 C. (100.8 F.), the pulse rate was 98 and the respiratory rate was 25. The boy did not appear to be severely ill, but his nose was almost completely obstructed and respirations were noisy. The tonsillar lymph nodes were enlarged even to inspection but were only moderately tender. The tonsils were smooth and fiery red and met in the midline, completely obscuring the posterior pharyngeal wall. They showed no membrane on admission. The remainder of the examination showed no significant generalized glandular enlargement; the spleen was not palpable, and there was no exanthem and no jaundice.

TABLE 1.—*Agglutination Test in Case 1*

	Before Adsorption with Guinea Pig Kidney	After Adsorption [5]
Hot titer	1:40 1+	1:320 1+
Cold titer	1:640 2+	1:320 1+

Laboratory Data on Admission.—The reaction to 1 mg. of tuberculin was negative; the Schick and the Kahn reactions were negative. The erythrocyte count was 4,340,000 per cubic millimeter and the hemoglobin content 12.5 Gm. per hundred cubic centimeters. The leukocyte count was 21,500, of which 62 per cent were neutrophilic polymorphonuclears (9 nonsegmented), 36 per cent lymphocytes which were characteristic of type 1 Downey cells [3] and 2 per cent monocytes. The platelets were normal. The bleeding and clotting times were normal.

Course in the Hospital.—The boy's temperature rose shortly after admission and stayed between 39 and 40 C. (102.2 and 104 F.) for the next four days. During this period the throat was painful and tracheotomy seemed almost necessary at times because of the respiratory obstruction caused by the tonsillar mass. On his sixth hospital day the temperature reached normal and remained so until his discharge, on the eleventh day. On his second hospital day a slight membrane was noted on the tonsils; on the third day a slight but definite generalized glandular enlargement was observed and the spleen became palpable. These changes persisted for about five days.

On October 2 blood was drawn for a sheep cell agglutination test; [4] the results are given in table 1.

On the day of discharge the child was greatly improved. The tonsils and tonsillar lymph nodes had regressed to a small fraction of their former size. The leukocyte count had fallen to 6,800 cells per cubic millimeter, with a differential showing 38 neutrophilic polymorphonuclears, of which 12 were nonsegmented forms, and 62 lymphocytes characteristic of Downey type 1 cells. The result of a sheep cell agglutination test was essentially the same as previously.

The boy was observed one month later with mumps and six months later because of some diminution in hearing in the left ear. Hematologic studies were not repeated.

CASE 2.—*History.*—G. S., a Negro girl aged 9 months, had one older sibling, and the family history was irrelevant. The family had moved to Connecticut from the South when the patient was 6 months of age. The Kahn reaction of the maternal blood was negative in this laboratory. My first contact with the patient was when she was brought to the clinic, at the age of 7 months, because of a rat bite on the foot. Treatment consisted in injection of antitetanus serum and repeated observation for spirochetal disease. The child was bitten on the hand by a rat one week after the first trauma. This wound was cauterized and observation continued. No systemic disease developed.

TABLE 2.—*Agglutination Test in Case 2*

	Before Adsorption with Guinea Pig Kidney	After Adsorption
Hot titer	1:2,560 3+	1:2,560 1+
Cold titer	1:2,560 3+	1:2,560 1+

From the Department of Pediatrics, Yale University School of Medicine, and the Children's Clinic of the New Haven Hospital.

1. Bernstein, A.: Infectious Mononucleosis, Medicine **19**: 85 (Feb.) 1940. Wintrobe, M. M.: Clinical Hematology, Philadelphia, Lea & Febiger, 1942.

2. Longcope, W. T.: Infectious Mononucleosis with a Report of Ten Cases, Am. J. M. Sc. **164**: 781 (Dec.) 1922.

3. Downey, H., and McKinlay, C. A.: Acute Lymphadenosis Compared with Acute Lymphatic Leukemia, Arch. Int. Med. **32**: 82 (July) 1923.

4. Paul, J. R., and Bunnell, W. W.: The Presence of Heterophile Antibodies in Infectious Mononucleosis, Am. J. M. Sc. **183**: 90 (Jan.) 1932.

5. Stuart, C. A.; Welch, H.; Cunningham, J., and Burgess, A. M.: Infectious Mononucleosis, Arch. Int. Med. **58**: 512 (Sept.) 1936.

At the age of 8 months the baby was treated in the pediatric service of the hospital for left lower lobe pneumonia; no satisfactory pathogenic organisms were isolated from the nose and throat. Response to sulfathiazole was prompt, and the child was discharged on the sixth hospital day. The Kahn reaction of the blood was negative at the time of this admission. During the ensuing month the patient was seen five times in the dispensary for rhinopharyngitis.

Present Illness.—Five days previous to her present admission the child's rhinopharyngitis became worse. The temperature rose to 39 C. (102.2 F.) and the child became increasingly fretful and was admitted because of the possibility of recurrent pneumonia.

Physical Examination.—The temperature was 40.1 C. (104.2 F.), the pulse rate 132 and the respiratory rate 56. Breathing was rapid and shallow, but the general condition was good. The throat was fiery red, with a significant amount of mucopurulent material present. Small patches were seen on the gums and on the buccal mucosa. There was no generalized glandular enlargement. The spleen and liver were not enlarged, and there was neither exanthem nor jaundice.

Laboratory Data.—The reaction to 0.02 mg. of tuberculin was negative and the Schick reaction was negative. The blood count on admission revealed erythrocytes 4,000,000, hemoglobin content 10 Gm. per hundred cubic centimeters and leukocytes 20,000. Differential count of one hundred leukocytes showed 78 polymorphonuclears, of which 12 were nonsegmented forms, 21 lymphocytes and 1 monocyte. On the seventh hospital day the total leukocyte count had fallen to 11,450, with 64 per cent polymorphonuclears, 28 per cent lymphocytes, 5 per cent monocytes, 2 eosinophils and 1 basophil. On the twelfth hospital day the leukocyte count was 10,850 with 44 per cent polymorphonuclears, 52 per cent lymphocytes, 2 per cent monocytes and 2 per cent eosinophils.

TABLE 3.—*Riboflavin Content of Diet in Case 2*

Evaporated milk diluted half and half	130 micrograms per 100 cc.
Puréed carrots (canned)	50 micrograms per 100 cc.
Puréed spinach (canned)	105 micrograms per 100 cc.
Apple sauce (canned)	33 micrograms per 100 cc.
Apricots (canned)	75 micrograms per 100 cc.
Prunes (canned)	142 micrograms per 100 cc.
White potato	50 micrograms per 100 cc.
Butter	None

Unfortunately, notes were not made of the specific nuclear or cytoplasmic patterns of the lymphocytes, and the blood films were not filed for future reference. Determinations of the serologic reactions of the blood made on the first, third and seventh days showed the Kahn to be 4 plus and the Wassermann negative. Tests done on the last specimen of blood by the Connecticut Department of Health [6] showed the complement fixation test to elicit a positive reaction and the micro Hinton a doubtful one. Cultures of material from the rhinopharynx revealed beta hemolytic streptococci and Haemophilus influenzae, not of type b. Culture of material from the throat yielded no pathogens. The blood was negative on culture. Two cultures of the white membrane of the mouth yielded Monilia. Dark field examinations of the blood showed no spirilla. Cultures of whole blood for Spirillum minus and Streptobacillus moniliformis were negative on two occasions. Agglutination tests using the patient's serum against known strains of Streptobacillus were made twice, also with negative results. A sheep cell agglutination test (performed largely because of an unexplained positive Kahn reaction with an oral membrane) gave the highest titer ever observed in this clinic. The results are given in table 2.

Course in the Hospital.—The patient was treated with sulfathiazole in the usual dosage. The temperature became normal forty-eight hours after her admission, except for one transient period of moderate elevation. The pharyngeal membrane continued to spread, and the voice became hoarse, which suggested laryngeal involvement. Gentian violet locally and 50 mg. of nicotinic acid by mouth were used for four days, without improvement; this was followed by one dose of 3 U. S. P. units of crude liver extract intramuscularly and 5 mg. of riboflavin by mouth daily. Within forty-eight hours after initiation of this therapy the buccal mucosa had lost all traces of the white membrane. Because of the clinical course, ariboflavinosis was suggested as an etiologic factor for the oral lesions, but the dietary history does not support such an assumption.

Rough calculation of the riboflavin content of the diet (table 3) shows it to be well in excess of 500 micrograms, the minimum standard set by the National Research Council, Committee on Foods and Nutrition. From the age of 3 months to the present illness, at 9 months the child was fed on a basic milk mixture of evaporated milk (1 quart daily). She had had no orange juice for the preceding two months and no cod liver oil for the previous five months. From the age of 4 months, except during periods of illness, the patient had been given average amounts of puréed carrots, spinach, apple sauce, apricots and prunes (all commercially canned), as well as pablum and white potato with butter.

The child was seen twice in the dispensary for unrelated complaints, two months and four months respectively after she was discharged; she was apparently in good general health, and the buccal mucosa was normal.

COMMENT

Case 1 is typical of certain cases of infectious mononucleosis as seen in white children. Case 2 does not present the typical systemic and hematologic picture, but in an infant this is not surprising. The extraordinarily high titer of her serum for sheep red cells and the atypically positive Kahn reaction following a negative reaction six weeks before is strong evidence for the diagnosis.

The use of the Stuart modification of the Paul-Bunnell test gives highly specific results and is of particular value in cases such as that of the girl, for whom horse serum had been used two months previously.

The exact cause of the disease has not as yet been determined, although a virus is thought to be the most probable etiologic agent; if so, it is difficult to understand why the disease should spare Negroes. It is probable that many cases have not been reported because the disease generally has an exceptionally low mortality and only a moderate morbidity, and no specific treatment has yet been universally accepted.

CONCLUSIONS

1. Two cases of infectious mononucleosis observed in Negro children are believed to be the first serologically proved cases in the literature. One previous case of the disease in a male Negro was reported by Longcope.

2. No explanation can be offered for the apparent rarity of the disease on a racial basis.

6. This test and all the sheep cell agglutinations were done by Dr. F. L. Mickle, director.

Council on Pharmacy and Chemistry

NEW AND NONOFFICIAL REMEDIES

THE FOLLOWING ADDITIONAL ARTICLES HAVE BEEN ACCEPTED AS CONFORMING TO THE RULES OF THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION FOR ADMISSION TO NEW AND NONOFFICIAL REMEDIES. A COPY OF THE RULES ON WHICH THE COUNCIL BASES ITS ACTION WILL BE SENT ON APPLICATION.

AUSTIN E. SMITH, M.D., Secretary.

PHENOBARBITAL (See New and Nonofficial Remedies, 1943, p. 502).

The following dosage forms have now been accepted:

BUFFINGTON'S INC., WORCESTER, MASS.

Compressed Tablets Phenobarbital: 16 mg., 32 mg. and 0.1 Gm.

WILLIAM R. WARNER & CO., INC., NEW YORK

Tablets Phenobarbital: 16 mg., 32 mg. and 0.1 Gm.

SULFADIAZINE (See New and Nonofficial Remedies, 1943, p. 169).

The following additional dosage form has been accepted:

LEDERLE LABORATORIES, INC., PEARL RIVER, N. Y.

Sulfadiazine, 2½ W/V in Ethanolamines Solution (Pickrell): 8 ounce and one pint bottles. Sulfadiazine 2.5 per cent in an aqueous medium containing triethanolamine-technical 8 per cent w/v, with sodium benzoate 0.2 per cent as a preservative.

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SATURDAY, APRIL 29, 1944

REPORTS OF THE OFFICERS AND BOARD OF TRUSTEES

The reports of the officers and the Board of Trustees of the American Medical Association, which appear in the Organization Section of THE JOURNAL this week (pp. 1261-1367), constitute a remarkable record of achievement under most difficult conditions. New peaks are announced for every phase of the Association's activities. True, there was some diminution in Fellowship occasioned by entrance of Fellows into military service, but even here the reduction was minimal, and membership in the Association was actually increased. The net gain and the income from the publications of the Association rose amazingly, owing in large part to a decrease in employed personnel, to restrictions on the use of paper and to inability to replace old equipment and purchase new machinery. Nevertheless, this testifies also to the dynamic efforts of those who carried on the work of the headquarters office handicapped by lack of secretarial and other usual assistance.

The reports of all the Councils of the Association merit reading and study by every physician who has at heart the progress and welfare of medical education, medical ethics and medical science. These Councils blanket the field of medical interests and proffer their collective efforts and wisdom for the good of the people and the medical profession. The Council on Pharmacy and Chemistry (p. 1266), aided by the Laboratory, leads in the advancement of scientific treatment and has been of great help to governmental agencies in the control of unwarranted medicaments. More and more manufacturers seek voluntarily to cooperate with this Council. In the development of physical therapy the Council devoted to that field (p. 1268) has been a most important stabilizing influence. At a time when our knowledge of nutrition goes forward in ascending tempo, the Council on Foods and Nutrition (p. 1269) analyzes the available evidence and issues scientific pronouncements which guide the medical profession, industry, educational leaders and governmental bodies. The Council on Industrial Health (p. 1270) has urged the county and state medical societies, industrial agencies and individual physicians into recognition of the importance of medicine in the great industrial expansion that marks our modern way of life.

Four of the Councils—Judicial, Medical Education and Hospitals, Scientific Assembly and Medical Service and Public Relations—report directly to the House of Delegates. The Judicial Council (p. 1300) offers some timely wisdom on medical ethics, the problem of fees for service and the questions likely to arise with the return of men now in the armed forces. The Council on Medical Education and Hospitals (p. 1301) has been intensively engaged in the difficulties created by selective service; the accelerated teaching, intern and resident programs; the evolution of medical schools; postwar medical problems, and the growth of the accessory medical technologic professions. The Council on Scientific Assembly (p. 1304) guided the development of material for THE JOURNAL in the absence of an annual session last year and now offers for 1944 a wartime assembly program that will speak for itself when the preliminary announcement is published in the near future. The Council on Medical Service and Public Relations (p. 1304) has made notable progress in completing its organization, establishing two regular bulletins, holding several important sessions and opening a Washington office.

Another technic by which the American Medical Association functions is the utilization of special committees. In this issue appear also the reports of the Committees on Wartime Graduate Medical Meetings (p. 1290), an outstanding accomplishment for extending graduate education in wartime; Air Conditioning (p. 1290); Motor Vehicle Accidents (p. 1290), and War Participation (p. 1307). There are reports of special conferences concerned with hospital practice, optometry, cultism, conservation of vision and similar subjects. Scientific research, largely dominated in wartime by the Office of Scientific Research and Development, was nevertheless also aided through the grants of the Committee on Scientific Research (p. 1204) and the Committee on Therapeutic Research (p. 1207).

The Bureaus of the American Medical Association are conducted by full time employees who have been, during this period, under unwonted stresses but who nevertheless have functioned with efficiency. The report of the Bureau of Health Education (p. 1272) reveals the innumerable public contacts made through this office with its pamphlets, radio programs, meetings and liaisons, as well as by the Bureau of Public Relations (p. 1284) through newspaper, periodical, radio and organizational relationships. The Bureau of Legal Medicine and Legislation (p. 1271) offers eight pages of analysis of congressional and other activities related to medical control. The Bureau of Medical Economics (p. 1285), burdened largely with data for the procurement and assignment of physicians for the armed forces, aided later by the liaison office from the Army Medical

Department (p. 1204), also analyzed prepayment plans and traced the evolution of medicine's own efforts to meet the problem of better distribution of medical care. The Bureau of Investigation (p. 1289) found its work diminished by activities of the post office department, which regulates abuse of the mails, the Food and Drug Administration and the Federal Trade Commission, but it cooperated with these agencies and with the Better Business Bureaus and continued its program of public enlightenment on nostrums and quackery. The Bureau of Exhibits (p. 1288), also hard pressed, made available graphic demonstrations of medical progress through constituent societies and affiliated organizations from coast to coast.

Under extraordinary difficulties the Library of the Association continued its direct services to physicians with indexes, references, package libraries and the QUARTERLY CUMULATIVE INDEX MEDICUS. From the presses of the Association rolled forth tons of scientific periodicals, representing without doubt the best available in the world today, and popular educational articles and pamphlets which were extensively reprinted in digest magazines and trade journals.

Who, reading these reports, and feeling the impact of the work they represent, can criticize unfavorably with any justice the efficiency of the American Medical Association? Its accomplishments have aroused the admiration of leaders in every other profession in this country as well as that of hundreds of visitors from most of the allied nations who have come to the headquarters during the war years. There have been some who have envied, others who would destroy, still others who would seek to change completely the character of the American Medical Association to that of an organization like a union, a commercial business or a political pressure group. Yet the founders and the leaders of the American Medical Association through the years have held steadfast to the principles enunciated in its constitution and in its ethics:

"The objects of the Association are to promote the science and art of medicine and the betterment of the public health" (Constitution of the American Medical Association, article 2).

"A profession has for its prime object the service it can render to humanity; reward or financial gain should be a subordinate consideration. The practice of medicine is a profession. In choosing this profession an individual assumes an obligation to conduct himself in accord with its ideals" (Principles of Medical Ethics of the American Medical Association, chapter I, section 1).

Who, reading the reports of the officers and of the Board of Trustees can say that they have not, with diligence, with efficiency and with honor, upheld the ideals of the Association and carried out the mandates of the House of Delegates? Who, reading the reports, would wish to exchange the activities, the results and the progress of this voluntary organization of physicians, functioning as a democracy, for the iron bound regulations of commercial or labor groups, or for the wasteful futility and inefficiency of governmental bureaucracy?

THE BARUCH GIFTS FOR THE ADVANCEMENT OF PHYSICAL THERAPY

Elsewhere in this issue (General News, p. 1311) appears a statement concerning a gift of $1,100,000 given by Mr. Bernard M. Baruch on April 26 to be used for teaching and research in physical medicine. Physical medicine includes, under the definition of this gift, the treatment of disease by extensive physical agents, including light, water, heat and electricity as well as by exercise and massage. Mr. Baruch appears to have been stimulated particularly to make his gift now because of the indications that physical therapy will be able to do much for the rehabilitation of the wounded and disabled who are already being released from the armed forces and who are likely to come with increasing numbers as the invasion goes on.

For some time a well qualified committee, headed by Dr. Ray Lyman Wilbur, has been studying the technic of approach to proper use of the funds which Mr. Baruch has now made available and which will no doubt be greatly supplemented in the future. Dr. Simon Baruch, distinguished father of Mr. Bernard Baruch, was himself a pioneer in this field. His name is associated with much of the progress that has been made, particularly in New York State. Because of Mr. Baruch's childhood associations in the state of Virginia and his career in New York, the institutions to which the funds are first to be devoted are the Columbia University College of Physicians and Surgeons, the New York University College of Medicine and the Medical College of Virginia. However, funds are also provided for grants to other medical schools and for the establishment of fellowships and residencies.

Thus the committee has recognized the basic importance of sound education and research to further progress in this field as in other fields of medicine. No doubt the work will be extended to some of the well recognized spas and health resorts of the United States, concerning which such excellent reports have recently been made available by the Committee on Spas and Health Resorts of the American Medical Association.

In no other field of medical science has there been, since long before the time of Hippocrates, as much difficulty in dissociating the vast mass of that which is good from a considerable portion of thought based on the will to believe and the power of suggestion. A fundamental step in the progress of this work will be the establishment of mechanisms under sound educational and well controlled auspices to separate the false from the true, the scientific from the fallacious, the honest from the fraudulent. When such reports become available they will do much to determine not only the path of future progress but also the trend of scientific medical practice.

DEFERMENT OF PREMEDICAL AND MEDICAL STUDENTS

According to the most recent directive issued by the national headquarters of the Selective Service System, preprofessional students of medicine, dentistry, veterinary medicine and various other fields will be liable to early induction into the Army if they have not matriculated and engaged in actual classroom work in schools of medicine, dentistry and veterinary medicine prior to July 1, 1944. Unfortunately this directive of the Selective Service System, issued on April 11, does not take into account the fact that acceleration of the medical curriculum, the registration of freshman classes every nine months and the varying dates on which different medical schools converted their activities from the old schedules to the wartime accelerated program have combined to change completely the dates of admission in many medical schools. Thus, one freshman class is admitted in May, another in June, two classes in July and August, twenty-one classes in September, twenty-five in October and three in November. If the directive issued by the Selective Service System on April 11 is not modified, many prospective freshmen medical students in fifty-three schools will have their status threatened. Thus far representatives of all the agencies interested in medical education have sought to obtain an extension of date to Oct. 1, 1944, but without avail.

Recently the following memorandum was circulated under the auspices of the Association of American Medical Colleges to the deans of medical schools:

> After consideration of all the factors involved, it is the recommendation of the Executive Council that medical schools whose next incoming class is scheduled to begin instruction not later than next October matriculate on June 30 all civilian students accepted for that class who are under occupational deferment and assume technical responsibility for the class room instruction in appropriate subjects, which may include courses in the premedical sciences conducted in the university, particularly in instances where students must complete their minimum premedical requirements.

Several deans have indicated that they may not follow this recommendation, since it might appear to be a direct evasion of the Selective Training and Service Act. Certainly it is unfortunate that medical education should even have to consider evasion or subterfuge in order to maintain continuity of medical education during the war.

A recent conference of the Surgeons General of the Army, the Navy and the Public Health Service with the Procurement and Assignment Service brought forth emphatic agreement that some means of providing an uninterrupted flow of medical students is fundamental to the nation's health and welfare. The indeterminate attitude of the War Manpower Commission on this question has served to interfere seriously with the morale of medical students and teachers, and with the quality of medical education.

Enough has been said in the press and elsewhere to indicate that a critical shortage of physicians now exists and that an adequate schedule for replacement is a national necessity. Since the beginning of the Selective Service program, the status of professional students has been continuously a matter of doubt. Is it not possible to secure assurance of deferment? If not, the War and Navy departments will do well to secure through those departments some type of inactive or reserve status for qualified premedical and medical students. Unless a continuous flow of medical graduates can be assured, every one at all interested will have to take the matter directly to the Congress and the President.

Current Comment

LIMITED PENICILLIN FOR CIVILIAN USE

Under the direction of the War Production Board the manufacture of penicillin has been greatly increased in the past year. While the needs of immediate military and OSRD war research must always necessarily be met first, the board now finds that a limited supply is available for restricted use in civilian medical practice. Assisted by an advisory panel, the board is formulating a plan for a controlled but equitable distribution of some of the drugs throughout the entire United States. Details of the program will be announced shortly in THE JOURNAL. The War Production Board and the collaborating drug manufacturers are to be commended for their achievements in developing production and for the intelligent and fair manner in which limited distribution for civilian needs is being planned.

HOSPITAL CARE FOR MOTHERS

Only a few years ago critics of the medical profession were charging that a large percentage of births received inadequate medical attendance. In 1935 records of the type of such attendance were obtained for the first time. The Bureau of the Census has recently issued a special report entitled "Live Births by Person in Attendance: United States, 1942, March 24, 1944." This shows a steady and rapid increase in the percentage of births attended by a physician in hospitals—from 36.9 per cent in 1935 to 67.9 per cent in 1942. The number attended by physicians not in the hospital declined in the same period from 50.6 per cent to 24.7 per cent. The percentage of births attended by midwives has fallen from 10.7 per cent to 7.0, and those attended by "other and not specified" from 1.8 per cent to 0.4 per cent. In the states of Iowa, Kansas, Massachusetts, Nebraska, New Hampshire, Ohio, Pennsylvania and Vermont and in the District of Columbia approximately 100 per cent were attended by physicians. The Southern states and especially the races other than the white race afford the only examples where more than 50 per cent of the births did not have a physician in attendance.

MEDICINE AND THE WAR

ARMY

ARMY MEDICAL DEPARTMENT ESTABLISHES CIVIL PUBLIC HEALTH DIVISION

Major Gen. Norman T. Kirk, the Surgeon General of the Army, has announced the establishment of the Civil Public Health Division as a new organization with its principal function the formulation of policies and the development of plans for public health programs in occupied and liberated territories during the military phase of future operations.

The division, part of the Preventive Medicine Service under Brig. Gen. James S. Simmons, will be under the immediate direction of Col. Thomas B. Turner, M. C., who has just returned from an extensive tour of the European and Mediterranean theaters of operations, where such programs are now functioning or are in the planning stage.

The program already under way will integrate the public health activities of the Army overseas with that of other agencies in this field, including the U. S. Typhus Commission, the Navy, the U. S. Public Health Service, the United Nations Relief and Rehabilitation Administration and other national and international health organizations.

The Allied armies will be called on to assume a measure of responsibility for civilian public health in many areas, entailing supervision of or liaison with local public health officials and the provision of certain necessary medical supplies.

To accomplish this objective it will be necessary to commission from civil life a number of officers experienced in public health administration and in specialties such as nutrition, maternal and child health, public health engineering and laboratory technics.

Men who have had both general and special training in one or another of these special fields are being sought for such assignments in the Far Eastern area. They should not be over 50 years of age and should be physically qualified to perform at least limited service duties overseas. Previous military experience and knowledge of foreign languages is desirable but not essential.

The men selected will undergo a course of training at the School of Military Government, Charlottesville, Va., and thereafter in one of a number of civilian universities not yet designated. Instruction will include the theory and general principles of military government and liaison, and the language and background of certain Far Eastern areas. In addition provision will be made for training men in special phases of public health and certain medical specialties.

Further information may be obtained by addressing the Surgeon General, U. S. Army, Washington 25, D. C., attention Civil Public Health Division.

PRAISE LITTER BEARERS ON FIFTH ARMY FRONT

The War Department recently announced that litter bearers on the Fifth Army front, who evacuate the wounded to first aid stations, where they receive life giving plasma, are saving many lives and reducing appreciably the extent of casualties. These unarmed "medics" disregard enemy shells, mines and booby traps and ignore fatigue and discomfort in carrying out their missions. Often the first aid stations are several miles from the point where casualties are picked up, and in extremely mountainous terrain and in weather which makes the precipitous trails most hazardous, bearers often average from twelve to eighteen hours carrying a single patient. Stretchers must be kept perfectly level when bearing the seriously wounded. To accomplish this in rugged terrain takes the efforts of at least six bearers.

Typical of first aid detachments is the medical battalion commanded by Lieut. Col. Frank P. Pipia, Medical Corps, Brooklyn. Under the supervision of Capt. James L. Rounds, Medical Corps, Chicago, the battalion's litter bearers did a remarkable job in evacuating the wounded from the mountains in the Cassino sector, where stiffened enemy resistance resulted in heavy casualties. Ambulances and jeeps could get no closer than 7 to 10 miles of the wounded. Relay stations were set up at intervals, and volunteers from armored and antiaircraft units helped the medics carry the wounded over the slippery mountain trails. Captain Rounds described the feat of one of his men, Corporal James Bowers, of Shelbyville, Mo., who rescued eight wounded infantrymen within sight of the enemy. Corporal Bowers, with seven litter bearers, reached the advanced outpost after an all night climb. He raised his Red Cross flag and with his men in full view of the enemy marched out to get the wounded. Fortunately in this instance the Germans withheld their fire and the wounded were successfully evacuated. "The medical detachments are filled with men like Bowers," Captain Rounds asserted. "Those men are accomplishing heroic missions almost every time they go up. Artillery and mortar shelling, as well as mines and booby traps, are constant dangers. The other day I met one of my noncoms who had just spent several days in a sector under severe artillery attack. When I asked how things were going up there he replied casually 'Just the usual shelling, sir.'" Captain Rounds urged the use of the term "combat medics" for these front line litter bearers. "The medics," he said, "are not considered combatants because they do not carry rifles, but I believe they should be known as 'combat medics' because they share all the dangers and discomforts of infantrymen."

ARMY WARNS AGAINST BOGUS AID FOR BLINDED SOLDIERS

The War Department recently issued a warning to the public to be on guard against fraudulent solicitation of funds based on pleas for aid to blinded soldiers. Despite the fact that the Army Medical Department has announced that thus far 73 men have suffered total blindness in this war, medical officers have reported circulation of misinformation and rumors that there are thousands of blind casualties. Several hoaxes already have been detected. In one instance in a West Coast city three blind men, none of whom ever had been in the military service, were represented in a newspaper story as veterans who had been blinded in action against the Japanese in the South Pacific. The blind men did not know that they were to be described as ex-soldiers and repudiated efforts to use them as pawns in the scheme. In two states, on two occasions, funds have been solicited on the strength of representations that the money collected would be used for training and care of the blind.

The Army Medical Department gives complete care to blind soldiers and retains them in hospitals until they have received the maximum benefit from their treatment, including reeducation and training for adjustment to civil life. Guide dogs are furnished to those who want them. Reputable guide dog agencies are cooperating in exposing efforts to hoax the public, and these legitimate organizations have furnished or have offered to furnish guide dogs for the nominal charge of one dollar or gratis to veterans needing them. The Surgeon General's Office estimated that only about 10 per cent of blinded servicemen will need or want guide dogs. Some blinded persons learn to use a cane skilfully and thus can get about less conspicuously and without the encumbrance of a dog. Medical officers have found that a blinded soldier should not, under any circumstances, have a dog until he has become as independent and self reliant as possible.

Blinded veterans are at present being cared for at the Valley Forge General Hospital, Phoenixville, Pa., and the Letterman General Hospital, San Francisco.

PROCUREMENT AND ASSIGNMENT SERVICE FOR PHYSICIANS, DENTISTS AND VETERINARIANS

RELOCATION OF PHYSICIANS

From January 1942 to Feb. 29, 1944, 2,955 relocations of physicians to new localities of practice were effected, according to an announcement made by Dr. Frank H. Lahey, chairman of the directing board of the War Manpower Commission's Procurement and Assignment Service. Dr. Lahey estimated that the total in March would be approximately 250.

Since 1942, through March 31, 1944, state chairmen of Procurement and Assignment Service have reported 510 areas as being critically short of medical personnel. Of these areas the needs for medical personnel were met in 281 communities, or 55 per cent of the critical areas. Relocations were effected in 135 of these communities, and the needs of 146 were met "by other means." Dr. Lahey explained that among the methods included in the phrase "by other means" were inducing retired physicians to resume active practice, changes in types of medical practice and "freezing" of medical personnel in civilian communities by Procurement and Assignment Service classification as "essential."

The needs of 185 communities have not yet been met. In 166 areas there appears at present to be no solution, and only temporary or partial solutions have been effected in 16 areas. It was explained that "temporary or partial" solutions include temporary deferments of men otherwise available for military service, temporary relocations and the utilization of part-time physicians from neighboring areas.

The main difficulties in the way of permanent solutions for some communities are to be found in such factors as the following, Dr. Lahey pointed out:

1. To a large extent, relocations must be effected within the various states themselves because of restrictions in medical licensure laws which prohibit outside physicians from practicing.

2. There is a serious problem involved in finding qualified older physicians who are not already firmly established and who are willing to move to other areas where their services are needed.

3. It is sometimes difficult to find physicians who, although they are otherwise qualified, are acceptable to local communities.

As a cross section of communities whose medical facilities have been hard hit by the war and for whom no solution has yet been found, Dr. Lahey called attention to the following:

1. Mobile, Ala., first reported to the Procurement and Assignment Service as being a critical area on Oct. 26, 1942.
2. Key West, Fla., first reported on Jan. 29, 1943.
3. Vallejo, Calif., first reported on March 18, 1943.
4. Velasco, Texas, first reported on Jan. 14, 1943.

HOSPITALS NEEDING INTERNS AND RESIDENTS

The following hospitals have indicated to the Council on Medical Education and Hospitals that they have not completed their house staff quota allotted by the Procurement and Assignment Service:

(Continuation of list in THE JOURNAL, April 22, page 1210)

FLORIDA

Orange General Hospital, Orlando. Capacity, 263; admissions, 4,475. Mr. C. DeWitt Miller, Superintendent (1 intern).

ILLINOIS

Mercy Hospital, Chicago. Capacity, 360; admissions, 7,701. Sister Mary Redempta, R.N., Superintendent (1 intern).

Mount Sinai Hospital, Chicago. Capacity, 280; admissions, 7,576. Dr. Stephen Manheimer, Director (resident—July 1).

IOWA

Mercy Hospital, Cedar Rapids. Capacity, 179; admissions, 3,862. Sister Mary Mercy, R.N., Superintendent (interns, residents).

Broadlawns, Polk County Hospital, Des Moines. Capacity, 174; admissions, 2,823. Mr. T. P. Sharpnack, Administrator (interns—July 1, October 1).

LOUISIANA

Shreveport Charity Hospital, Shreveport. Capacity, 788; admissions, 11,116. Dr. Edgar Galloway, Superintendent (3 interns, resident, pathology—October 1).

NEBRASKA

Lincoln General Hospital, Lincoln. Capacity, 213; admissions, 4,574. Mr. Robert B. Witham, Administrator (interns).

NEW YORK

Brooklyn Eye and Ear Hospital, Brooklyn. Capacity, 143; admissions, 6,893. Mr. Henry J. Williams, Superintendent (residents, otolaryngology—1944-45).

Queens General Hospital, Jamaica, L. I. Capacity, 696; admissions, 9,925. Dr. Henry I. Fineberg, Superintendent (residents, otolaryngology, contagious, July 1; assistant resident, urology, pediatrics—October 1).

New York Post-Graduate Medical School and Hospital, New York City. Capacity, 409; admissions, 8,622. Dr. William B. Talbott, Superintendent (resident, urology—July 1).

Highland Hospital, Rochester. Capacity, 266; admissions, 5,249. Dr. George B. Landers, Director (3 interns—September).

OHIO

Grant Hospital, Columbus. Capacity, 313; admissions, 8,624. Mr. Erwin C. Pohlman, Superintendent (interns).

Miami Valley Hospital, Dayton. Capacity, 445; admissions, 12,484. Mr. O. K. Fike, Director (3 interns, 1 resident—October 1).

TEXAS

El Paso City-County Hospital, El Paso. Capacity, 211; admissions, 2,973. Dr. A. H. Butler, Superintendent (2 interns—August 1).

All Saints Episcopal Hospital, Fort Worth. Capacity, 100; admissions 3,997. Miss Eva M. Wallace, R.N., Superintendent (2 general residents—1 now, 1 in August).

MISCELLANEOUS

AWARDS FOR OUTSTANDING CONTRIBUTIONS TO THE REHABILITATION OF THE WAR INJURED

Four awards of $1,000 each were presented on April 20 for outstanding contributions to the Rehabilitation of the War Injured at the Lord and Taylor Seventh Annual American Design Awards luncheon at the Waldorf-Astoria. Dr. Thomas Parran, Surgeon General of the U. S. Public Health Service, was guest speaker. Walter Hoving, president of Lord and Taylor, made the presentations. The recipients were:

Lieut. Col. Howard A. Rusk, M. C., formerly of St. Louis and now chief of the Convalescent branch in the Office of the Air Surgeon, for his program of convalescent reconditioning now in effect throughout the country. His program prepares the patient both mentally and physically for recovery, so that he is able to return to combat or enter into productive civilian life.

Lieut. Col. James Barrett Brown, M. C., formerly of St. Louis and one of the founders of the American Board of Surgery, for his work on plastic surgery. Dr. Brown was made chief of Plastic Surgery at the Valley Forge General Hospital in May 1943.

Lieut. Col. Roy R. Grinker, M. C., and Major John P. Spiegel, M. C., jointly for neuropsychiatry. Dr. Grinker was formerly head of psychiatry at the University of Chicago and director of neuropsychiatry at Michael Reese Hospital, Chicago. At present he is chief of Professional Services and Psychiatry at the Don Ce-Sar Convalescent Center set up by the Air Forces. Dr. Spiegel, a former pupil of Dr. Grinker's, was resident in psychiatry at the Michael Reese Hospital, Chicago, and left in 1942 for active service in the Army Air Force. He was sent to Africa with the invasion of that continent in November 1942 and worked with Dr. Grinker.

Capt. Henry H. Kessler, M. C., formerly of Newark, N. J., as representative of the Navy program for orthopedic rehabilitation. Dr. Kessler served as medical director of the New Jersey Rehabilitation Clinic from 1919 to 1941, at which time he entered active service. He is well known for the development of an artificial arm and accompanying operation which utilizes live muscles left in the stump, thus affording the patient muscular and coordinative control of the artificial limb.

ORGANIZATION SECTION

REPORTS OF OFFICERS

NOTE.—At the 1925 session of the Association, the House of Delegates suggested that all reports of officers, committees, etc., and resolutions to be brought before the House, if available, be published in advance of the session so as to permit careful consideration and discussion.—Ed.

REPORT OF THE SECRETARY

To the Members of the House of Delegates of the American Medical Association:

The following report of the Secretary is respectfully submitted:

MEMBERSHIP

On Dec. 31, 1943 the official membership list of the American Medical Association carried the names of 123,586 members. During the year the names of 2,019 deceased members were removed. There was a net gain of 1,876 over the number of enrolled members as of Dec. 31, 1942.

Because a reapportionment of delegates is made every third year based on the number of members recorded on April 1 of the reapportionment year, it has been customary to report annually the enrolment as of that date. On April 1, 1944, 124,452 members were enrolled. On the corresponding date in 1943 the recorded membership was 122,741.

It appears that many young physicians, recently graduated, were accepted into the armed service as medical officers and were assigned to duty before they had opportunity to affiliate as members of component county medical societies and constituent state and territorial associations and have therefore not qualified as members of the American Medical Association.

It also appears that an undetermined number of component county medical societies have closed their membership books for the duration of the war. Whether or not such action has been taken by resolutions adopted or under specific provisions of constitutions and by-laws is not known to your Secretary.

An accompanying table shows, with respect to each state, the number of counties, the number of component county medical societies, the number of counties in which no societies are now organized, the number of physicians as shown by the Seventeenth Edition of the American Medical Directory, the number of members as reported by the constituent state and territorial medical associations on April 1, 1944 and on April 1, 1943, and the number of Fellows in each state and territory.

On Dec. 31, 1943 the names of 70,269 Fellows appeared on the Fellowship roster, while on the same date in 1942 the enrolment of Fellows was 73,453. During the year, 931 deaths of Fellows were reported. The names of 186 Fellows were removed from the roster because of ineligibility, 342 were dropped because of nonpayment of dues and 4,169 Fellows resigned. Most of those who resigned were Fellows who had accepted commissions as medical officers and had been assigned to active duty with the military forces.

As of April 1, 1944 the number of enrolled Fellows was 69,304. On April 1, 1943 the enrolment was 72,851. The decrease in Fellowship has not been as large as was expected. Some of the loss has been made up by the enrolment of new names.

PROPOSED AMENDMENT TO THE CONSTITUTION, ARTICLE 6, SECTION 3

Dr. Arthur S. Risser, delegate of the Oklahoma State Medical Association, submitted the following resolution, in which amendment of the Constitution, article 6, section 3, is proposed, to the House of Delegates at its annual meeting in Chicago in 1943. In accordance with the provisions of the Constitution and By-Laws, this proposed amendment will be before the House of Delegates for action at the 1944 session:

WHEREAS, The American Medical Association is composed of the fifty-four constituent state and territorial medical associations; and

WHEREAS, Twenty-two of these state associations lie west of the Mississippi River and are considered more or less rural states where the problems of medicine and public health are different from those of the industrial states; now therefore, be it

Resolved, That the house of delegates of the Oklahoma State Medical Association instruct its delegates to introduce the following amendment to the Constitution of the American Medical Association:

Organization of Constituent State and Territorial Medical Associations, April 1, 1944

	Number of Counties in State	Number of Component County Societies in State	No. of Counties in State Not Organized		No. of Physicians in State 17th Ed. A. M. Directory	No. of Members of State Associations		Number of Fellows in State
			1943	1944		1943	1944	
Alabama	67	67	..	..	2,123	1,565	1,560	646
Arizona	14	13	1	1	615	390	390	259
Arkansas	75	58	11	9	1,806	1,070	1,008	423
California	58	40	6	10	12,365	7,314	7,550	5,229
Colorado	63	37	1	1	1,886	1,151	1,175	687
Connecticut	8	8	..	..	2,720	1,937	2,011	1,061
Delaware	3	3	..	..	360	245	243	125
Dist. Columbia	..	..	..	..	4,540	924	947	795
Florida	67	34	17	16	2,391	1,425	1,429	1,006
Georgia	159	92	37	37	2,814	2,005	2,014	815
Idaho	44	9	..	..	446	320	319	173
Illinois	102	92	6	6	12,548	8,587	8,623	4,496
Indiana	92	86	1	1	4,165	3,344	3,397	1,604
Iowa	99	97	..	..	3,102	2,446	2,407	1,114
Kansas	105	72	18	16	2,042	1,560	1,587	838
Kentucky	120	112	3	4	2,717	1,886	1,949	739
Louisiana	64	42	15	15	2,601	1,551	1,567	858
Maine	16	15	..	..	1,011	751	757	748
Maryland	23	23	..	..	3,085	1,597	1,635	1,004
Massachusetts	14	18	..	..	8,085	5,542	5,528	2,773
Michigan	83	55	..	..	6,509	4,415	4,567	2,229
Minnesota	87	54	1	1	3,614	2,945	2,976	1,320
Mississippi	82	21	3	3	1,525	973	923	403
Missouri	114	78	8	8	5,183	3,254	3,252	1,757
Montana	56	17	22	22	556	436	453	206
Nebraska	93	59	16	16	1,637	1,147	1,119	616
Nevada	17	5	12	12	174	124	114	74
New Hampshire	10	10	..	..	687	546	540	266
New Jersey	21	21	..	..	6,008	4,178	4,294	2,406
New Mexico	31	14	17	17	447	272	268	173
New York	62	61	1	1	27,928	18,624	18,908	10,436
North Carolina	100	67	24	24	2,871	1,912	1,942	964
North Dakota	53	13	11	11	520	408	399	195
Ohio	88	87	1	1	9,406	6,783	6,752	3,487
Oklahoma	77	63	6	6	2,284	1,504	1,493	716
Oregon	36	28	2	1	1,405	1032	982	486
Pennsylvania	67	60	6	5	13,503	9,922	9,951	5,347
Rhode Island	5	6	1	1	958	613	755	356
South Carolina	46	37	4	4	1,427	922	911	489
South Dakota	69	12	1	1	495	339	341	188
Tennessee	95	57	24	24	2,961	1,756	1,815	854
Texas	254	126	..	..	6,952	4,308	4,607	2,318
Utah	29	9	4	4	585	481	505	279
Vermont	14	10	3	3	351	383	378	184
Virginia	100	52	8	8	2,920	1,862	1,868	1,237
Washington	39	24	13	13	2,234	1,645	1,644	992
West Virginia	55	30	5	5	1,834	1,337	1,352	610
Wisconsin	71	52	..	..	3,551	2,587	2,627	1,376
Wyoming	24	11	11	11	263	190	190	101
Alaska	..	..	..	..	79	38	37	36
Hawaii	5	4	1	1	395	341	345	108
Canal Zone	..	..	..	..	181	126	250	32
P. I. (provinces)	56	28	28	28	4,269	1,247	1,247	42
Puerto Rico	7	7	..	..	526	470	470	67
Foreign	..	..	..	..	17	..	..	93
	3,139	2,054	349	347	185,903	122,741	124,452	65,206
Commissioned medical officers								4,098
								69,304

Amend article 6, section 3, by adding the following language:
"After the adoption of this amendment, the House of Delegates shall elect at the earliest possible time at least three Trustees from the states west of the Mississippi River, and all appointments to fill unexpired terms of these Trustees shall be from states west of the Mississippi River and that this ratio of members shall at all times be retained."

Memorials and Resolutions

No memorials or resolutions have been submitted for inclusion in the Handbook of the House of Delegates, though attention has been directed to a number of resolutions adopted by component societies and constituent associations, which, presumably, will be submitted to the House by delegates.

Visitors and Correspondence

The number of members of the Association who visit its offices is constantly increasing, and it is with much pleasure that this fact is reported to the House of Delegates. All who come are invited to visit the offices of all the councils, bureaus and departments and to make such inquiries as they may be disposed to make. Many have taken full advantage of the opportunity to learn at first hand something of the nature and scope of the activities of the Association.

Many physicians of other countries have similarly honored the Association and, until very recently, there has been a continuous increase in the number of such visitors.

The number of lay visitors is constantly growing. Pupils of schools, college students, teachers and members of civic groups are among our visitors and seem to be interested in what they see and hear in reply to their inquiries.

On numerous occasions the facilities available at the Association's building have been utilized by both professional and lay groups for official meetings of such groups. In all instances those in attendance have been given full opportunity to observe the activities of the various departments and to familiarize themselves with the aims and objects of the Association in relation to the promotion of the art and science of medicine and to public service.

The volume of correspondence that pours into the Association's offices, aside from that coming from physicians, is very large and is constantly increasing. Effort is made to offer helpful replies to all inquiries, the nature of which is almost unbelievably varied, as are the sources from which they come.

Activities incident to the matters referred to in this section of the report of the Secretary represent an important part of the work of the Association in the field of public relations.

In Appreciation

The Secretary offers to the members of the House of Delegates, to the officers and the members of official bodies of the Association, to officials of state and county medical societies and to many individual members of the Association an expression of his heartfelt thanks for their kindly consideration and aid. Especially does he wish to express to his associates of the administrative personnel and other loyal and faithful employees his grateful appreciation. They have carried on in the face of difficulties in a manner that deserves high commendation.

Respectfully submitted.

Olin West, Secretary.

REPORT OF THE BOARD OF TRUSTEES

To the Members of the House of Delegates of the American Medical Association:

Income and Expenditures

The official Reports of the Treasurer and Auditor are appended as a part of this report of the Board of Trustees.

Examination of the figures presented will reveal that income from all sources in 1943 was larger than in any previous year, and that the excess of income over expenditures was far larger than ever before. The net gain in 1943 was $718,873.76, exceeding the net gain reported in 1942 by the sum of $388,458.42. This remarkable increase in income over expenditures was the result of unexpectedly large receipts on various accounts. Income from Fellowship dues and subscriptions to The Journal was greater by the sum of $19,497.08; advertising receipts of The Journal increased by $159,494.08, and receipts from the sale of advertising space in the Association's periodical publications aside from The Journal showed a gain over 1942 of $38,546.94; income from the sale of books, reprints and sundry items produced a gain of $26,064.27; interest on investments was greater in 1943 than in the previous year by $8,261.50, and the gain of income over expenditures from Association periodicals other than The Journal was $72,231.81. Income from subscriptions to all of the Association's publications, exclusive of Fellowship dues, was larger in 1943 by the sum of $47,302.35.

Along with the remarkable gain in various income items there were rather significant reductions in expenditures incident to the operation of various councils, bureaus and committees and of some departments. Such expenditures were less in 1943 than in 1942 by the sum of $35,078.61, and sundry expense items including legal expense were $21,395.91 less than in the preceding year. The cost of paper used in the production of the Association's periodical publications was reduced in 1943 as compared with similar costs in 1942 by the sum of $42,002.54. Total wages and salaries paid in 1943 were less than in 1942 by $122,369.95. Significant reductions were recorded in expenditures for postage, supplies and building maintenance, while there were increased expenditures for ink, commissions and cash discounts.

The foregoing detailed information is included in this report in explanation of the remarkable gain in net income in 1943. While it became necessary to adjust salary and wage schedules upward, the reduction in expenditures for these purposes was considerable in amount because of the serious depletion of personnel. Had it been possible to secure adequate personnel, the outgo for salaries and wages would have been rather radically increased. Smaller expenditures for paper were occasioned by the action of official agencies of the federal government whereby rather severe restrictions were placed on paper supplies, compelling the utilization of paper of less weight than had previously been used and radically reducing the total amount of paper allotted for the Association's use. Under normal conditions rather large expenditures would have been made for machinery and other equipment, but this has not been available because of conditions created by the war. Other supplies that would normally have been purchased have not been on the market for the same reason. The Board of Trustees has set up a reserve of $300,000 to be used for the purchase of new machinery and for the replacement of parts of old machinery that will still be usable when properly repaired.

Summary

Income from all sources in 1943 was larger than in any previous year, and the excess of income over expenditures was larger than ever before. The net gain in 1943 was $718,873.76, exceeding the net gain for 1942 by the sum of $388,458.42. This remarkable increase was the result of unexpectedly large receipts on various accounts, including Fellowship dues and subscriptions by the sum of $19,497.08, Journal advertising receipts by $159,494.08 and advertising receipts from the Association's periodical publications by $38,546.94, the sale of books and reprints and sundry items by $26,064.27 and interest on investments by $8,261.50. Income from subscriptions to all of the Association's publications, exclusive of Fellowship dues, was larger than in 1942 by the sum of $47,302.35.

Along with the gain in various income items there were significant reductions in expenditures incident to the operation of various councils, bureaus, committees and departments, such expenditures being $35,078.61 less in 1943. Legal expense also was less by the sum of $21,395.91, the cost of paper was $42,002.54 lower and total wages and salaries were less than in 1942 by the sum of $122,369.95.

The reduction in the amount of wages and salaries paid was due to the depletion of personnel, and the smaller expenditures for paper were occasioned by the restrictions placed on its use by the federal government. Under normal conditions rather large expendi-

tures would have been made for new machinery and other equipment and supplies. The Board of Trustees has set up a reserve of $300,000 to be used for this purpose when such material is available.

Group Life Insurance and Retirement Annuity Plan

For several years it has been apparent to the members of the Board of Trustees that it would be desirable and even necessary for the Association to initiate a plan under which retirement annuities could be provided for the benefit of the Association's employees. This necessity has been accentuated by conditions growing out of the global war.

The Board of Trustees, after lengthy consideration, has entered into a contract with a long-established insurance company which provides for group life insurance and for retirement annuities. The cost of the retirement annuity plan is borne by the Association and its employees who are eligible under the terms of the contract. The plan provides for the payment of annuities to all eligible employees at the age of 65. New employees will be eligible to participate in the plan after the first six months of continuous employment. The amount of annuity will be based on the employee's length of service and earnings and will include current service annuity purchased during service after April 1, 1944 and past service annuity purchased for service before April 1, 1944 in accordance with specific provisions of the contract pertaining to annuity payments. The cost of past service annuity for employees who entered the plan on April 1, 1944 and who on that date have completed at least one full year of continuous service after attaining the age of 35 will be borne by the Association, while contributions by the employees and by the Association will be used each year to purchase current service annuity.

Group life insurance is provided for all employees.

Within a relatively short period of years, retirement annuity plans have been put into effect by practically all large industrial and commercial employers as well as by philanthropic and scientific organizations, and this practice has no doubt contributed toward the establishment of incentive for continuous employment by efficient and loyal employees and has enabled employers to make provision toward insuring at least some degree of financial security for faithful workers in their nonproductive years.

Employment

At one time in 1941 there were 678 persons in the employ of the Association. In 1943 the number of employees had dwindled to slightly more than 500. As this report is being prepared there are approximately 515 persons on the Association's employment list, a considerable number of whom are replacements. Practically every department has suffered severely for lack of needed personnel, and the difficulties involved in securing replacements appear to be increasing rather than diminishing.

The Association has attempted to comply with federal and state laws pertaining to employment and with regulations promulgated by administrative agencies. Forty-two members of the Association's working personnel have been assigned to active duty with the military forces, while several others have failed to qualify for such service largely because of minor physical defects. At least one of the group assigned to active duty has been decorated for meritorious performance, while most of the others have been promoted in rank.

The Journal of the American Medical Association

THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION continues to be recognized as the leading general publication in its field. The aim of THE JOURNAL has been to present material regarding scientific advancement in medicine, reports of official bodies of the American Medical Association, editorial discussions of problems affecting various aspects of medical science and medical care, and the medical news of the world.

The exigencies of war have interfered greatly with the receipt of material which normally would have come from correspondents to THE JOURNAL in other countries. Nevertheless, advantage has been taken of the opportunity to enlist new correspondents from South American nations and to develop those sections of THE JOURNAL devoted to the war service of the medical profession and to the activities of government agencies.

As of Dec. 31, 1942, 103,692 names appeared on the mailing list of THE JOURNAL, while on Dec. 31, 1943, there were 108,452 names on this list, which included subscribers, exchanges, advertisers, subscription agents and others. The circulation of THE JOURNAL in 1943 was larger than ever before, as was the income received from subscriptions and the sale of advertising space. The weekly average of copies of THE JOURNAL printed in 1943 was 105,324.

Included in this report is the usual table showing the number of Fellows and the number of subscribers other than Fellows in each state, and the gain or loss in circulation. A second

TABLE 1.—*Approximate Count of Fellows and Subscribers on The Journal Mailing List Jan. 1, 1944, Showing Gain or Loss*

States	Fellows	Sub-scribers	Totals	Gain	Loss
Alabama	588	378	966	..	27
Arizona	236	166	402	..	17
Arkansas	385	228	613	..	58
California	4,754	3,846	8,600	1,054	..
Colorado	625	373	998	..	33
Connecticut	965	734	1,699	25	..
Delaware	114	87	201	..	..
District of Columbia	723	914	1,637	273	..
Florida	915	577	1,492	..	12
Georgia	741	631	1,372	..	50
Idaho	158	106	264	13	..
Illinois	3,642	3,248	6,890	..	113
Indiana	1,459	793	2,252	9	..
Iowa	1,013	431	1,444	..	36
Kansas	702	333	1,095	..	38
Kentucky	672	417	1,089	..	123
Louisiana	780	588	1,368	17	..
Maine	317	182	499	..	10
Maryland	940	900	1,840	131	..
Massachusetts	2,521	1,757	4,278	..	123
Michigan	2,027	1,643	3,670	137	..
Minnesota	1,200	689	1,889	..	8
Mississippi	367	295	662	..	15
Missouri	1,598	1,098	2,696	44	..
Montana	188	105	293	6	..
Nebraska	560	342	902	67	..
Nevada	68	42	110	9	..
New Hampshire	242	108	350	..	39
New Jersey	2,188	1,407	3,595	..	164
New Mexico	158	126	284	19	..
New York	9,354	7,211	16,465	1,134	..
North Carolina	904	741	1,645	99	..
North Dakota	178	93	271	..	5
Ohio	3,170	1,576	4,746	..	295
Oklahoma	651	343	994	24	..
Oregon	442	433	875	3	..
Pennsylvania	5,043	3,042	8,085	..	2
Rhode Island	324	186	510	..	47
South Carolina	445	315	760	..	50
South Dakota	171	128	299	17	..
Tennessee	777	621	1,398	138	..
Texas	2,108	1,380	3,488	3	..
Utah	254	173	427	35	..
Vermont	168	78	246	..	1
Virginia	1,125	675	1,800	..	16
Washington	902	615	1,517	60	..
West Virginia	555	291	846	..	7
Wisconsin	1,251	652	1,903	..	62
Wyoming	92	50	142	..	16
U. S. Army	...	2,016	2,016	1,452	..
U. S. Navy	...	1,500	1,500	800	..
U. S. P. H. S.	...	152	152	48	..
Alaska	28	29	57	3	..
Canada	13	1,010	1,023	199	..
Cuba	6	286	292	42	..
Hawaii	104	109	213	..	22
Mexico	9	255	264	55	..
Panama	32	42	74	..	29
Philippine Islands	..	..	..	..	..
Puerto Rico	61	95	156	3	..
Virgin Islands	1	3	4	..	2
Foreign	56	2,176	2,232	315	..
Advertisers and agents	..	..	319	..	69
Exchanges	..	..	186	15	..
Complimentaries	..	..	97	..	10
Total on mailing list			108,452	6,249	1,480

table indicates the number of physicians in each state, the number receiving THE JOURNAL and the approximate percentage of subscribers in each state.

It may be of interest to the members of the House of Delegates to know that in 1900 there were 8,445 Fellows and 4,633 subscribers other than Fellows carried on the mailing list of THE JOURNAL, while in 1943 the names of 59,030 Fellows and 48,820 other subscribers appeared on this list. It is to be remembered that several thousand Fellows of the Association substitute special journals for THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION in connection with Fellowship.

TABLE 2.—*Percentage of Physicians Receiving The Journal* *

State	Number Receiving Journal	Physicians in A. M. Directory	Approximate Percentage Receiving Journal
Alabama	966	2,123	46
Arizona	402	615	65
Arkansas	613	1,806	34
California	8,600	12,265	70
Colorado	998	1,886	53
Connecticut	1,699	2,720	62
Delaware	201	360	56
District of Columbia	1,687	4,540	36
Florida	1,492	2,391	62
Georgia	1,372	2,814	49
Idaho	264	446	59
Illinois	6,800	12,548	55
Indiana	2,252	4,165	54
Iowa	1,444	3,102	47
Kansas	1,055	2,042	54
Kentucky	1,080	2,717	40
Louisiana	1,368	2,601	53
Maine	499	1,011	49
Maryland	1,840	3,085	60
Massachusetts	4,278	8,085	53
Michigan	3,670	6,509	56
Minnesota	1,989	3,614	52
Mississippi	662	1,525	43
Missouri	2,696	5,183	52
Montana	293	556	53
Nebraska	902	1,637	55
Nevada	110	174	63
New Hampshire	350	687	51
New Jersey	3,595	6,008	60
New Mexico	284	447	64
New York	16,465	27,928	59
North Carolina	1,645	2,871	57
North Dakota	271	500	59
Ohio	4,746	9,406	50
Oklahoma	994	2,284	44
Oregon	875	1,493	59
Pennsylvania	8,085	13,503	60
Rhode Island	510	958	53
South Carolina	760	1,427	53
South Dakota	299	493	61
Tennessee	1,398	2,961	47
Texas	3,488	6,952	50
Utah	427	585	73
Vermont	246	551	45
Virginia	1,800	2,900	62
Washington	1,517	2,234	68
West Virginia	846	1,834	46
Wisconsin	1,903	3,551	54
Wyoming	142	263	54

* This table gives the number of physicians (based on the Seventeenth Edition of the American Medical Directory) in the United States, the number receiving THE JOURNAL and the approximate percentage in each state. Copies to physicians in the United States Army, Navy and Public Health Services are not included.

Summary

The Journal of the American Medical Association continues to be recognized as the leading general medical publication. War conditions have interfered greatly with receipt of material from foreign correspondents, but advantage has been taken of opportunities to enlist new correspondents from South American countries and to develop those sections of The Journal devoted to war service of the medical profession and activities of government agencies.

The circulation of The Journal in 1943 was larger than ever before, as was the income received from subscriptions and the sale of advertising space. There were 108,452 names on The Journal mailing list on Dec. 31, 1943, of which 59,030 were the names of Fellows of the Association.

Special Journals

The high quality of the nine special scientific journals published by the Association was maintained in 1943, although the number of pages in all but one of these periodicals was curtailed about one third during the second half of the year. The number of pages was reduced in order that official demands of the War Production Board restricting the use of paper might be complied with and in anticipation of a considerable reduction in the amount of material available for publication. In order that paper supplies might be conserved, publishers were urged by the War Production Board to reduce the number of illustrations used.

The ARCHIVES OF OPHTHALMOLOGY presented fourteen colored plates during the year, while one or more such plates appeared in some of the other special journals. Part of the expense incurred in reproducing these colored illustrations was borne by the Association and part by the authors of the articles with which the illustrations were used.

There were two special numbers of the ARCHIVES OF SURGERY, one in honor of Dr. Robert B. Osgood and the other presenting a symposium on gastric cancer which comprised twelve separate articles. The special number in honor of Dr. Osgood comprised thirty-four illustrated articles contributed by his former associates. A complete review of orthopedic surgery and the usual trimonthly reviews of urologic surgery were printed in the ARCHIVES OF SURGERY in 1943. The review of orthopedic surgery has been prepared by an editorial board of the American Academy of Orthopedic Surgeons, and there has been a considerable demand for reprints of these articles. The Chief Editor of the ARCHIVES OF SURGERY, Dr. Waltman Walters, has been on active service as a medical officer of the United States Navy during the entire year, and Dr. Lester R. Dragstedt, a member of the Editorial Board, has acted as Chief Editor pro tem.

The publication in the ARCHIVES OF INTERNAL MEDICINE of reviews of the literature on a number of subjects has been continued, although it has become somewhat difficult to secure preparation of such articles because many of those who have undertaken the task in the past are in active service with the armed forces or are heavily burdened with work because their associates have been called to active duty.

A series of articles on the effects of radiation on normal tissues by Dr. Shields Warren, publication of which was begun in 1942, was completed in the ARCHIVES OF PATHOLOGY in 1943.

WAR MEDICINE, which was published bimonthly in 1942, was made a monthly periodical in 1943, and the number of pages was increased slightly in order to give early publication to material of timely importance. Articles on occupational therapy were printed in WAR MEDICINE during the year and have since been reproduced in book form.

Only one of the nine special journals was published at a loss in 1943, and in that one instance the loss sustained was less than half the loss recorded in 1942. Income derived through the publication of this group of journals exceeded cost by the sum of $47,451.06.

The total circulation of the special journals in 1943 was in excess of that in 1942 by 2,710. In the case of only one of these journals was there a decrease in circulation, and that was very slight in amount.

Summary

The high quality of the nine special scientific journals published by the Association was maintained in 1943, although the number of pages and of illustrations was curtailed about one third during the latter half of the year in order to comply with demands of the War Production Board restricting the use of paper. War Medicine, published as a bimonthly in 1942, was made a monthly periodical in 1943 in order that early publication might be given to material of timely importance in connection with the war effort.

Only one of the special journals was published at a loss in 1943, and income derived from the publication of the whole group exceeded cost by the sum of $47,451.06. The total circulation of the special journals in 1943 exceeded that of the preceding year by 2,710 copies.

Library

The periodical lending service offered by the Library of the American Medical Association lent 9,641 separate issues of periodicals in 1943. This number is lower than that of 1942 because greater restrictions were placed on the lending of foreign periodicals. As it is now impossible to replace periodicals published in Axis controlled countries, fewer such items are included in package libraries. They were included only when other material was not available on a requested subject.

More than 2,200 package libraries were lent to members and to subscribers of the publications of the American Medical Association. The majority of the requests came from Illinois, New York, California, Indiana and Pennsylvania. Approximately one half of the requests for service came from physicians and students in the various military services of the United States. The subjects most frequently requested during the year were military medicine, industrial and occupational diseases, pneumonia (virus or atypical), anesthesia, aviation medicine, sulfonamides, burns, tuberculosis and blood transfusion. As usual, the Library answered hundreds of miscellaneous reference questions.

Indexes for the three volumes of THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION published in 1943 were prepared in the Library.

The Employees' Library, which has been maintained for many years, was discontinued during the year owing to a shortage of personnel.

Quarterly Cumulative Index Medicus

There was some increase over 1942 in the number of foreign articles indexed in the QUARTERLY CUMULATIVE INDEX MEDICUS for the year 1943. In 1940, 26,614 articles from foreign publications were included in the INDEX MEDICUS. In 1942 the number of such foreign articles available for indexing dropped approximately 50 per cent to 13,424. Of this number 64 per cent of the articles were indexed from Spanish and Portuguese journals. In 1943, 16,525 articles from foreign periodicals were indexed. Fifty-four per cent of this total were from Spanish and Portuguese journals.

About 1,860 articles from microfilms of periodicals published in Axis controlled countries were indexed. During the year a few German periodicals covering the year 1942, which were ordered in 1941 through the Joint Committee on Importations of the American Library Association, were received. The first shipment arrived in July 1943, and a smaller one followed a few weeks later.

About 168 periodicals, mostly foreign publications, were dropped during the year from the list of journals indexed in the QUARTERLY CUMULATIVE INDEX MEDICUS. Many titles of periodicals have been retained in the list, even though issues have not been received for three years. The staff of the INDEX has been greatly reduced, and unprecedented delays in publication have occurred because of the shortage of personnel.

The net loss sustained through the publication of the QUARTERLY CUMULATIVE INDEX MEDICUS in 1943 was $19,784.97, approximately $7,500 less than in 1942. This reduction in the costs of publishing and distributing the INDEX was most largely due to the forced reduction in the size of the volumes printed in 1943 because of the unavailability of material from foreign countries. If and when the normal flow of such material is resumed after the war, it is practically certain that the costs involved in the production of this publication will be very considerably larger.

Hygeia, the Health Magazine

The scope and influence of HYGEIA have multiplied increasingly in recent years, so that this magazine is now truly an official source book of education for the public concerning health and disease. Articles that have appeared in HYGEIA have been frequently quoted, and a number of them have been reproduced in such leading publications as the *Reader's Digest, Magazine Digest* and *Science Digest* and other similar magazines. Its articles and editorials have formed the basis for widespread comment in newspapers in various parts of the country, and a number of the articles and pictures have been included in textbooks, some having been selected not only for textbooks in the field of science but as models in the field of writing. Contributors to HYGEIA include some widely reputed writers.

During the past year special consideration of the interests of the blind and the deaf, as well as concise statements regarding advances in medical science, have been covered by articles that have been published in HYGEIA.

Advertisers have recognized the importance of representation in HYGEIA, so that the demand for advertising space has on some occasions been greater than could be met because of restricted paper allotments.

The average net paid circulation per month in 1943 was 115,846 copies, but toward the end of the year there was a decrease in the total number of subscribers. Because of a lack of paper, it was not possible to maintain the usual effort to procure new subscribers, with the result that the number of subscriptions secured through direct mail solicitation was smaller than in 1942. This loss was largely overcome as a result of an increased number of subscriptions secured through subscription agencies and part time subscription agents.

Income derived from subscriptions and from the sale of advertising space in the columns of HYGEIA was larger than the expenditures involved in its publication during 1943 by the sum of $52,758.79.

American Medical Directory

Because of the evident impossibility of procuring necessary office personnel and the unsettled conditions growing out of the war, it will be necessary to postpone the preparation and publication of the Eighteenth Edition of the American Medical Directory. In the meantime diligent effort will be made to maintain the records kept by the Directory Department so that the valuable information provided may be available for present and future purposes.

The entire issue of the Seventeenth Edition has been exhausted. Income received from sales in 1943 was large enough to reduce the loss reported last year by approximately $6,300.

Order and Mailing Department

The total number of orders handled by the Order Department during the year covered by this report was 64,858, approximately 8,500 less than in the preceding year. The total number of units distributed was 375,465, representing an increase of slightly more than 20,000.

One hundred and fifty tons of stock room mail were sent out, and more than 560,000 pieces of "metered" letter mail, not including thousands of letters mailed directly from various departments during the year.

Cooperative Medical Advertising Bureau

The Cooperative Medical Advertising Bureau in 1943 had its most successful year. The earnings of the Bureau amounted to $55,802.46, representing a gain of a little more than $13,000 over the preceding year. A complete financial statement was submitted to each cooperating state journal.

The gross advertising secured through the Bureau for the twelve months ended Nov. 30, 1943 amounted to $246,837.10. The cost of operation of the Bureau amounted to $13,539.83. The amount of commissions returned to the cooperating journals at the end of the year was $35,800, which was, of course, in addition to the regular monthly payments made to each of the participating journals.

At a meeting attended by most of the editors and business managers of the state medical journals, held in Chicago in June 1943, some dissatisfaction with the operations of the Cooperative Medical Advertising Bureau was expressed. This matter was brought to the attention of the Board of Trustees and, in compliance with a request emanating from those who were present at the conference referred to, two additional members, Dr. Stanley B. Weld of Connecticut and Dr. E. M. Shanklin of Indiana, were added to the membership of the Advisory

Committee to the Cooperative Medical Advertising Bureau. This committee has had two meetings, the first of which was somewhat informal in character. At the second meeting, which was attended by all members of the Advisory Committee and two members of the Board of Trustees, plans were considered for making some changes in operating methods, and it was decided that the Advisory Committee should have three official meetings each year.

Council on Pharmacy and Chemistry

The Council on Pharmacy and Chemistry has entered its fortieth year of service to the medical profession and to the public. This body, which consists of scientists of outstanding repute, has been responsible for more progress in promoting and establishing rational therapeutics than has any other body. Its members serve earnestly and unselfishly, without remuneration, and always with thought of the Council motto "Non sibi sed Medicinae" (Not for itself but for Medicine). The Council's contributions in the field of drug therapy during 1943 assured continued recognition of its leadership.

THE COUNCIL AND THE WAR EFFORT

The Council has continued to provide its services and findings for prosecution of the war effort. In addition to supplying information to members of the medical profession and other scientific groups, the Council has cooperated with governmental agencies, regulatory and advisory, made available standards and statements of actions and uses for drugs used in the armed forces, in industry and in civilian practice and has issued general status reports to aid in applying the newer knowledge of the treatment of certain diseases. The Council office, the Council members and consultants have been called on repeatedly to answer questions on therapeutic procedures, pharmacology, toxicology, nomenclature and drug substitutes.

Several individuals formerly with the Council office are in active service with the armed forces. Two of these are physicians. Another, who was an office assistant, recently received the award of the Legion of Merit. One Council member is on active service abroad and has been relieved of all Council duties until his return. Practically all the members serve on one or more special committees of the central bodies which are directing the war effort.

PROFESSIONAL RELATIONS

The Council continues to enjoy cooperative relationship with many agencies of the federal government and with other bodies, and it supplies information and other assistance whenever possible; included are the Army, Navy, U. S. Food and Drug Administration, Federal Trade Commission, U. S. Public Health Service, War Production Board, National Research Council, Office of the Alien Property Custodian, Federal Bureau of Investigation, Better Business Bureaus, Council on Dental Therapeutics and others.

The Council has maintained relations with representatives of the American Pharmaceutical Association and of several other associations and societies to promote helpful understanding of problems of mutual interest. Increasing use of the Council's facilities by medical groups has been encouraged whenever possible. In spite of the war the Council office received many visitors, a number of these being from countries in Central and South America. It seems that several of the Latin American countries may create organizations similar to the Council when the time seems propitious. Visitors are encouraged to return and to correspond freely.

The Council has continued to be of assistance to all other departments and has supplied much information and help. During the year a cooperative committee was formed by the Council on Pharmacy and Chemistry and the Council on Industrial Health to consider the preparation of a formulary designed for use in industry.

The Secretary of the Council attended several meetings of other groups to represent the Council, present its views and carry back useful information. Most of these meetings concerned topics of vital concern to the Council, and attendance by a Council representative was most profitable for all participating bodies.

The Council is receiving an increasing number of requests from newspapers and radio broadcasting companies concerning advertising claims directed to the public. Much help has been provided on this score, which undoubtedly accounts for increasing calls. Such cooperation is in the interest of public welfare and is encouraged heartily by the Council.

PUBLICATIONS

The distribution of Council sponsored publications during 1943 reached a new peak. During the year over 46,000 copies of New and Nonofficial Remedies, Useful Drugs, Epitome of the U. S. P. and N. F., Annual Reprints of the Reports of the Council and Glandular Physiology and Therapy were distributed. Of this number New and Nonofficial Remedies comprised 20,000 copies (half of these were distributed free to medical students of recognized schools). The total number of copies of New and Nonofficial Remedies distributed during 1943 was greater by 8,000 than that in 1942. The total distribution of Council publications during 1943 represented an increase of more than 100 per cent over 1942 and nearly 200 per cent over preceding years. It is felt that part of this increase is due to general improvements in the books, especially in N. N. R., and to a systematic attempt to bring these books to the attention of the medical profession. Some increase is due to the accelerated medical education plan and to purchases by the armed forces. Nevertheless it is hoped that this peak will be maintained and even surpassed in the future.

The figures for 1943 bring up to 426,000 the number of publications sponsored by the Council which have been distributed over the last twenty-one year period. Included in this figure are 185,000 copies of N. N. R., of which about 85,000 have been complimentary paper-bound copies issued to students in recognized medical schools. These figures do not include publications for which the Council is not solely responsible, for example, the A. M. A. Intern's Manual and The Vitamins.

RESEARCH

In addition to initiating and sponsoring research resulting from certain phases of problems facing the Council in its considerations, the Council maintains a Committee on Therapeutic Research, which considers applications for research grants. During 1943 twenty-three grants, ranging from $125 to $800, were issued by this committee. Thirty-eight articles have been published during the year as a result of work done under Therapeutic Research grants. The number of grants that have been issued since the formation of the committee in 1911 is 515. Many of these grants have aided research of extremely important nature which has contributed greatly to better knowledge of the prevention and treatment of disease. In other instances the sums covered only a small part of the total cost of the research project.

EDUCATIONAL ACTIVITY

In addition to the preparation of status reports, standards and statements of actions and uses of new drugs, the editing of several books and other duties, the Council and its office attempt to acquaint the medical profession and others with the Council's work and to provide information that is intended to aid in improving the health of the public, even though this information may not fall directly within the Council's prescribed considerations. To this end, exhibits on endocrinology, chemotherapy and tropical diseases are being prepared, and when they are completed they will be available for loan from the Association's Bureau of Exhibits. During the year the Secretary addressed twenty audiences on varied subjects and appeared on the radio for interview on thirteen occasions. Several of the radio appearances were recorded and will be reproduced elsewhere on local stations. Council members also provided addresses in their respective fields before widely scattered audiences. Many of the members made original contributions in public health, materia medica and educational fields.

The Council gave permission to the authors of several textbooks to use certain portions of New and Nonofficial Remedies. This publication is being quoted widely in books on drugs and therapeutics.

REPORTS ON DRUGS

The Council adopted for publication about thirty reports, consisting in part of statements concerning the use of aminophylline and related xanthine derivatives, ampuls of camphor, treatment of vaginitis associated with Trichomonas vaginalis, antiseptics and their criteria for evaluation, dosage and labeling of vitamin preparations, human convalescent measles serum and scarlet fever serum, local use of the sulfonamides in dermatology, organotherapy with a concentrated organic iodine solution, oral use of the sodium salt of sulfonamides, external use of cod liver oil, amphetamine sulfate in the control of obesity, estrogens in the palliative treatment of prostatic carcinoma, and massive doses of vitamin D in the treatment of refractory rickets. Several other statements deserve special mention: The Council presented a report reviewing the history and advantages of the metric system, ending with the statement that from now on the dosages in Council sponsored publications will appear only in the metric system, although conversion tables will be provided in each book for those who are not familiar with this system. Another very important and widely received report presented a review of the nomenclature of endocrine preparations. This was intended to dispel confusion regarding the identity of many of these agents which are sold under proprietary and nonrevealing names. Many requests for reprints of this article have been received. At the request of the Subcommittee on Venereal Diseases of the Committee on Medicine of the National Research Council and the Committee on Drugs and Medical Supplies, the Council prepared and published a report on the status of dichlorophenarsine hydrochloride, an antisyphilitic agent. It also sponsored a complete article on conception control and adopted criteria for the evaluation of contraceptives which are now being considered by the Council on the same basis on which this body considers other drugs.

The Council adopted for publication twelve monographs on new drugs and accepted for inclusion in New and Nonofficial Remedies approximately 220 drugs submitted by various manufacturers. This involved a consideration of almost 500 dosage forms and dosages. The Council also gave partial consideration to many other therapeutic agents but did not complete action because of insufficient data, submission of products late in the year or at the request of the manufacturer pending further investigation. Further, the Council reviewed the status of a number of official agents which have been included in New and Nonofficial Remedies for some years but the individual brands of which could be deleted because of the general knowledge which exists on these products. However, in each instance adequate statements of actions and uses and dosage will remain in New and Nonofficial Remedies and will be revised each year when the book is revised, or more often if indicated, so that members of the medical profession, manufacturers and advertising agencies may have ready access to claims which are considered acceptable by the Council.

EXPEDITING COUNCIL CONSIDERATION

During the past year a number of changes have been effected in Council procedure so that consideration of submitted drugs may be expedited and final action accomplished more quickly. It is felt that this streamlining will reduce to a minimum occasional complaints that the Council moves too slowly. Any prolonged delays from now on will be due entirely to failure of the manufacturer to submit adequate evidence or to effect requested revisions, or to the independent investigation of certain claims by actual trial in the laboratories or clinics of the Council members and their associates. Although the manufacturer is supposed to assume the responsibility of submitting adequate proof to support his claims, it is occasionally necessary for a Council referee to subject the product to actual trial to ascertain the validity of one or more of the claims. The Council members assume a grave responsibility in declaring a product acceptable or nonacceptable and they demand that the necessary data for careful consideration be available; this serves as protection to the physician, the public and the manufacturer.

The office personnel has again decreased in number during the year. It has been impossible to fill most of the vacancies because of lack of adequately trained persons. Nevertheless, by each individual assuming greater duties and by streamlining Council considerations it has been possible to increase the output of work even with the decreased personnel.

MEMBERSHIP

Dr. William C. Rose, who has been a member of the Council for seven years, was forced to resign because of the pressure of other duties. It was with great regret that Dr. Rose's resignation was accepted, because his contributions to the Council work have been many and invaluable. Dr. Eugene M. Landis, professor of physiology, Harvard Medical School, who is well known for his contributions to science, was elected to fill Dr. Rose's unexpired term.

During the year Dr. Austin E. Smith, Secretary of the Council, and Dr. Elmer L. Sevringhaus were appointed to membership on the U. S. P. Endocrine Products Advisory Board.

ANNUAL MEETING OF THE COUNCIL

During October the Council held its annual meeting. The topics discussed and actions taken included the formation of a committee to report on standards for parenteral solutions; preparation of a report on the treatment of "Vincent's angina" and the role in which the physician and dentist may play a part; limitation of multiple dose vials for parenteral administration which are likely to show significant contaminating bacterial proliferation; status of the official liver, stomach and digitalis preparations; formation of a committee to prepare several articles for the medical profession to explain the work of the Council; granting a request from an Argentine society for a Spanish translation of Glandular Physiology and Therapy; disadvantages of the use of mineral oils in foods; status of globin insulin, and the status of the Council's rules. The Council also gave consideration to limiting the dosage sizes of vitamins to be accepted in New and Nonofficial Remedies, adopted an improved form for presentation of articles to the Council, authorized the expenditure of funds for sterility tests on submitted products where the need seems indicated and reviewed the status of combined diphtheria toxoid and tetanus toxoid preparations. Other considerations included an invitation to two authorities to prepare for the Council a status report on the use of Haemophilus pertussis vaccine and human hyperimmune pertussis serum, the variations that are taking place in the contents of submitted drug preparations, apparently because of speeded up manufacturing programs, and the responsibility of manufacturers to notify the Council of errors in the manufacture and marketing of their Council accepted products. While these and the other topics discussed are of importance even in normal times, some of them assume added importance during wartime.

Summary

The Council on Pharmacy and Chemistry has entered its fortieth year of service to the medical profession and to the public. During 1943 the Council continued to be of material aid to those who are engaged in the prosecution of the war effort, and its facilities were called on for many and varied projects.

Relations with representatives of other organizations and other countries were furthered and encouragement given to increasing collaboration. Such mutual consideration is of much aid in solving problems of common interest. Of special note is the increasing frequency with which those who are in charge of advertising copy for newspapers and radio programs are turning to the Council for guidance.

The distribution of Council publications reached a new peak during the year with a total of 46,000 copies. This represents an increase of more than 100 per cent over the preceding year.

Twenty-three grants for research were issued, bringing the number of grants issued since 1911 up to 515.

New exhibits are being prepared on endocrinology, chemotherapy and tropical diseases and will be available for loan when completed. During the year the Secretary addressed twenty audiences and appeared for thirteen radio interviews. Some of these interviews were recorded for reproduction over other stations.

Thirty status reports and twelve monographs on new drugs were adopted for publication. The Council completed consideration on about 220 drugs submitted by various manufacturers and gave partial consideration to many others.

Council procedure has been changed to expedite considerations and permit conclusions to be reached more quickly. In view of these changes any prolonged delays from now on will be due entirely to failure of the manufacturer to submit adequate evidence and other information, or to independent investigation initiated by the Council to ascertain the validity of certain claims.

Dr. William C. Rose was forced to resign as a member of the Council because of pressure of other duties. Dr. Eugene M. Landis was elected to fill the unexpired term. Drs. Austin E. Smith and Elmer L. Sevringhaus were appointed to membership on the U. S. P. Endocrine Products Advisory Board.

At its annual meeting the Council discussed many topics, some of these being of special importance in time of war. A number of actions which will contribute to public welfare and rational therapeutics will result from these considerations.

The Chemical Laboratory

During 1943 the Chemical Laboratory continued to serve the medical profession as it has for over thirty-seven years. The work of the Laboratory throughout the year was primarily concerned with the chemical consideration of medicinal products for the Council on Pharmacy and Chemistry. Reports of the Council published in THE JOURNAL and articles from the Laboratory make available information concerning the identity, purity and strength of new chemotherapeutic agents.

The Laboratory maintained careful scrutiny of a large number of dosage forms of drugs submitted to the Council on Pharmacy and Chemistry by manufacturers. In some instances serious discrepancies between the labeling and the actual contents were found. In every such case, notification of the manufacturer resulted in prompt cooperation through recall of the substandard article from the market and the institution of adequate methods of product control. A published contribution from the Laboratory aided in calling attention to the presence of hydrocarbons in some nonboilable surgical gut tubing fluids.

In addition to many other products examined in 1943, the Laboratory was called on to assist in the elaboration of tests and standards by means of which uniformity in composition and action of newer therapeutic agents may be assured. Consideration was given to tests and standards for such substances as sulfamerazine and sulfapyrazine and their sodium salts—sulfamerazine sodium and sulfapyrazine sodium; diodoquin, aldarsone, octofollin, anthralin, globin insulin with zinc, propylene glycol, zinc insulin crystals, metamucil, premarin, mercurin and dymixal. The Laboratory served in connection with the revision of New and Nonofficial Remedies, 1943 and devoted much time to the provision of chemical information in reply to correspondence and to problems of nomenclature.

The Laboratory cooperated with the Bureau of Investigation in the examination of a number of products marketed to the public. In this connection the analysis of several cold permanent wave preparations was performed.

The Laboratory has aided the Library staff in the classification of various substances under proper chemical designations and has been of assistance to the advertising committee and to other departments of the Association by means of technical advice.

The Chemical Laboratory continues to enjoy cooperation with the laboratories of the American Dental Association, the U. S. Food and Drug Administration and many manufacturers in the consideration of chemical problems of drug standardization.

Summary

The Chemical Laboratory of the American Medical Association has continued its important work for the Council on Pharmacy and Chemistry in the examination and standardization of medicinal products offered to the medical profession and has aided other departments of the Association. Cooperation with governmental agencies, professional groups and manufacturers has been continued.

Council on Physical Therapy

Developments incident to the great world war have given impetus to further advancement in the field of physical therapy. Methods of proved value increasingly are being employed for the rehabilitation of persons injured in combat and in industrial pursuits, and new procedures are being developed. Occupational therapy is playing a major role in the rehabilitation program of the armed services and industry. The Council on Physical Therapy believes that its critical evaluation of physical and occupational therapy during the past eighteen years has vitally influenced the development of the field.

There has never been such a shortage of trained physicians and qualified technicians as now exists in the field of physical therapy.

The restrictions placed on raw materials have caused the manufacturers of physical therapy equipment to limit the development of new therapeutic and diagnostic devices. In some instances manufacturers sell their entire output to the armed forces or to the government for lend-lease purposes. Others have converted all of their resources to the fabrication of the materials of war. For these reasons fewer appliances have been submitted to the Council, and investigations of apparatus have been greatly curtailed. However, the Council has not been idle. Many problems have been studied that do not necessarily involve the use of apparatus. In fact, the Council believes that most of physical therapy consists in the application of exercise, heat and massage and the intelligent management of the patient. Several members of the Council have been engaged in reviewing the entire field of physical therapy and in studies that may make it possible to offer recommendations for initiating new projects in research and for the improvement of present methods of practice. This year the Council voted to consider contraceptive devices.

PUBLICATIONS

The Manual of Physical Therapy, a booklet which describes the applications of physical therapy agents and is especially prepared for wartime consumption, has entered its second printing. The Manual of Occupational Therapy, which was completed during the year, is now being reprinted. The latter publication was prepared in cooperation with the American Occupational Therapy Association and the Subcommittee on Rehabilitation of the National Research Council.

Members of the Council have been actively engaged in one or another phase of the war effort, and the assumption of such new duties has interfered with the revision and improvement of the Handbook of Physical Therapy. A number of the chapters are still not completed. The booklet Apparatus Accepted, which contains the names of accepted products and their manufacturers, has been revised and is ready for distribution.

Twenty-eight articles approved by the Council appeared in THE JOURNAL during the year.

ARTIFICIAL RESPIRATION

During the year the subject of artificial respiration received considerable attention from the Council. Reports on research and investigations concerning resuscitation have netted valuable information. The fourth year progress report of the five year survey of all methods for artificial respiration, both manual and mechanical, as used in emergency conditions has been reviewed. The accumulated information thus gathered from research, investigations and surveys reaffirms the Council's stand concerning the acceptance or rejection of devices for administering mechanically artificial respiration. It is the considered opinion of the Council that every competent person should know how to give artificial respiration by an approved manual method. Critical evidence indicates that the first five minutes of complete anoxia are the most important, and artificial respiration should be administered within this period if any great hope of survival of the patient is to be expected. The chances of survival are considerably lessened if artificial respiration

is applied later. Even though a mechanical appliance for giving artificial respiration has been proved efficacious if applied within the five minute period, it is certainly of no value to the asphyxiated victim if it is fifteen minutes away from the scene of the accident. This is one reason the Council has endorsed for many years the instructional program of the American Red Cross concerning manual methods of artificial respiration.

COUNCIL CONSULTANTS

Physical therapy embraces so many specialized fields that one body of twelve men can scarcely be expected to have critical and authoritative information on all problems that are presented to it. The Council is fortunate, therefore, in having groups of consultants who give their services gratuitously, as do the Council members, and advise on the problems arising in specialized fields.

Education.—Proper instruction and training of the physical therapy technician are of paramount importance. The Council has cooperated with the Council on Medical Education and Hospitals in revising the curriculum for schools for physical therapy technicians. The American Physiotherapy Association and the American Registry of Technicians of the American Congress of Physical Therapy have contributed valuable assistance. With the aid of the Consultants on Education, the Council has reviewed the physical therapeutic measures currently employed, and the results of this study are available to civilian, army and navy physicians through a set of stereopticon slides together with a syllabus. Designed for use at wartime medical meetings, these slides are available to physicians who may be directing classes or who participate in programs of scientific meetings. Information on this service may be obtained by writing to the Secretary of the Council.

Audiometers and Hearing Aids.—Manufacturers of hearing aids have continued to receive limited amounts of raw materials. With the help of its Consultants on Audiometers and Hearing Aids, the Council has pursued its examination of hearing aids and has published reports.

The Consultants are anticipating the development of postwar problems in the field of hearing and especially those created by combat and industrial injuries. The testing of the hearing of the school child has also received considerable attention.

The Council on Physical Therapy greatly appreciates the cooperation and advice it has received from such organizations as the American Academy of Ophthalmology and Otolaryngology, the American Otological Society, the American Laryngological, Rhinological and Otological Society and the American Society for the Hard of Hearing.

Ophthalmic Devices.—Devices to be considered by this group of consultants are as follows: charts for testing vision and muscle balance, charts and instruments for orthoptic training, apparatus for applying heat to the eyes, diagnostic instruments of an optical nature and special or tinted lenses for which specific therapeutic claims are made.

The Council on Physical Therapy is grateful to its Consultants, who have rendered most valuable aid on so many occasions.

ULTRAVIOLET RADIATION FOR DISINFECTING PURPOSES

Careful study has been given to the use of ultraviolet radiation for disinfecting purposes. The Council published a statement declaring its stand on the acceptance of ultraviolet lamps for this purpose entitled "Acceptance of Ultraviolet Lamps for Disinfecting Purposes." The Council will consider for acceptance ultraviolet lamps for use in operating rooms, clinics and cubicles in hospitals when such places are under the direction of qualified persons. The Council does not accept lamps claimed to be useful for sterilizing solids and liquids. The acceptance applies only to the disinfecting of air under controlled conditions. Hence, apparatus for which it is claimed that diseases caused by cross infection are eliminated or reduced when such apparatus is installed in public gathering places, waiting rooms, physicians' offices, theaters and the like will not be retained on the accepted list.

Summary

The Council on Physical Therapy during the war emergency has devoted most of its energies to reevaluation of physical therapeutic measures and to making this information available to the profession in civilian and military service. Unavailability of raw material and curtailment of production have restricted greatly the Council's consideration of apparatus.

The Manual of Physical Therapy and the Manual of Occupational Therapy have been reprinted. The booklet Apparatus Accepted has been revised. During the year, twenty-eight articles adopted by the Council were printed in The Journal.

Artificial respiration, both manual and mechanical, has been reviewed carefully by the Council. Its study and findings have confirmed the Council's previous stand. The Council's study of basic, tried and approved therapeutic measures is summarized in a set of slides designed for use at wartime medical meetings. Hearing aids and ultraviolet lamps for disinfecting purposes were devices that received attention during the year.

Council on Foods and Nutrition

During the year 1943 the Council on Foods and Nutrition has continued to exert its influence to encourage the production of high quality foodstuffs and insure fair representation of these foods to the public. In pursuit of this objective numerous food products have been considered by the Council with a view to acceptance, but as the year progressed the number of such submissions declined. This is felt to be due in part to the limitations placed on food supplies as a result of the war and perhaps more so to the change in Council policy determined on at the July meeting. It was decided that the Council limit its consideration of foods to special purpose foods, defined as those promoted for the use of population groups in relation to growth and development, and to those foods which because of their public health significance merit Council attention. The use of the Seal of Acceptance will be continued in connection with such foods. Producers of all other accepted foods, considered as general purpose foods, have been notified of this action of the Council and requested to discontinue use of the seal after a stipulated period of time.

With this lessening in activity with respect to consideration of individual food products, it is the desire of the Council to extend its activities in the field of nutritional education. It is proposed to do this in part by developing a closer working arrangement with groups which are devoting themselves to research and education in the field of nutrition. These are in particular the organizations which are more and more being set up by various branches of the food industry and those governmental agencies charged with supervision of the nation's food and nutrition. Through the medium of Council reports, opinion will continue to be expressed on points of nutritional significance, keeping the physician and allied workers abreast of new developments and clarifying old principles.

COUNCIL REPORTS

Several reports on topics of interest have been published this year. One served to point out the dangers of fat soluble vitamin loss which can occur as a result of the indiscriminate use of liquid petrolatum in certain foods and as a laxative. Council acceptance was withdrawn from those Council accepted food products which include liquid petrolatum as an ingredient.

The practice of enriching white flour, first advocated by the Council in 1939, was made compulsory for all bakers' white bread by governmental order in January 1943. The nutritive contribution made by enriched white flour to the average American diet was brought out in a special Council report. It was shown that the average diet in which enriched white flour is used along with small amounts of skim milk solids maintains a reasonably satisfactory nutritional status, whereas with the exclusive use of ordinary white flour in such a diet definite symptoms of thiamine deficiency develop.

With the increasing interest in enrichment of grain products it was deemed worth while to make a comparative study of the vitamin content of the many prepared cereal products now on

the market. Such a study was undertaken under a research grant from the Board of Trustees of the American Medical Association and a preliminary report covering the analyses of some sixty cereal products and the grains from which they are made has been published.

HANDBOOK OF NUTRITION

Publication of the planned series of articles in THE JOURNAL covering important nutritional topics was successfully completed. These articles were subsequently resubmitted to the authors for any revision or additions that might be necessary to include the latest information available on the subject and then the twenty-five articles were brought together, reedited and prepared for publication as the Handbook of Nutrition. This volume was ready for distribution at the end of the year.

VITAMINS—REVISION OF FOOD CHARTS

At the July meeting it was decided that many of the values indicating nutrient content of foods as shown in the pamphlet Food Charts were no longer accurate in the light of most recent data. It was voted to revise this booklet to include the latest information and this has been done, so that this popular booklet will be available shortly in revised form.

Note was taken of the wide variance in vitamin C content of different brands of canned citrus fruit juices and tomato juice. It was recognized that these variations are mainly due to growth conditions and processing methods. The Council hopes to determine on an optimal vitamin level for these canned juices at which the producers can aim, as a measure to increase the nutritional value of this food.

To assist in clarifying the vitamin statements carried on food containers it was decided to urge a uniform system of stating vitamin content on labels of cereal products with the hope of extending this plan later to other types of foods.

The increasing tendency to add vitamins to various types of food products, making foods such as milk and candy (with the exception of vitamin D in milk and vitamin A in margarine) carriers of vitamins, is not looked on with favor by the Council. On the other hand fortification of certain processed foods with vitamins or minerals to restore these substances to their natural level in the untreated food is considered a desirable nutritional practice. The Council took occasion to reaffirm its stand on the question of supplemental vitamins, namely that the vitamins which are so necessary for the maintenance of health should be obtained from the food eaten and not from capsules.

COOPERATION WITH OTHER COUNCILS

As a part of the program of the fifth Annual Congress on Industrial Health, a Symposium on Nutrition in Industry was presented in cooperation with the Council on Industrial Health. Topics of pressing interest in this field were discussed by nutritional authorities. Following the normal presentations a round table discussion was held.

The Council has been endeavoring to secure information on certain specific questions concerning nutrition in industry which have been brought to it by the Council on Industrial Health. These pertain to the value of the indiscriminate use of multivitamin preparations in industry, the protective effect of specific vitamins against industrial hazards, and provision of adequate diets for all types of workers. A report covering the information available on these questions has been prepared.

There is continuous cooperative effort with the Council on Pharmacy and Chemistry.

COUNCIL MEMBERSHIP

The Council membership has remained unchanged over the past year. Dr. Franklin C. Bing, who served very efficiently as Secretary for a number of years, resigned early in the year to assume a new post elsewhere. After an interval of several months he was succeeded by Dr. George K. Anderson, recently of the National Research Council.

Summary

The Council on Foods and Nutrition will no longer consider all types of food products for acceptance but only those which have special value in relation to the growth and development of population groups or that are of particular public health significance. Instead, the Council desires to devote more of its energies to nutritional education, working more closely with those groups of the food industry and government concerned with nutritional research and education. Reports will continue to be published on topics of nutritional interest.

A report has been published calling attention to the dangers of loss of fat soluble vitamins through the indiscriminate use of liquid petrolatum in foods or as a laxative. Another report showed the protective contribution made by enriched white flour to the average diet as contrasted to the deficiencies developing with the use of ordinary white flour in the same diet. The vitamin content of almost sixty prepared cereal products now on the market was determined, and a preliminary report was made showing these comparative values.

The series of articles on nutritional subjects which were recently published in The Journal was brought up to date by revision and published as the Handbook of Nutrition.

The pamphlet Food Charts will be revised to include latest analytic data. Effort will be made to set the optimal vitamin C level for canned citrus and tomato juices, which can be met by better growing and processing technics and so increase the nutritional value of these foods. Efforts are being made to standardize the vitamin statements on cereal foods to make them mean more to the average consumer. The Council disapproves of the growing practice of adding vitamins to all sorts of food products (with certain exceptions), believing that only the replacement of vitamins lost in the processing of foods is desirable. The principle of obtaining vitamins from the food eaten and not from capsules was reaffirmed.

This Council has cooperated with the Council on Industrial Health to assemble and present the information available on the pressing subject of nutrition in industry in the form of a symposium. Questions on certain specific nutritional problems of industry have received the careful attention of the Council.

Dr. Franklin C. Bing resigned as Secretary of the Council after serving in this capacity for a number of years. He was succeeded by Dr. George K. Anderson.

Council on Industrial Health

The Council on Industrial Health is able to report, as in other years, a constantly widening sphere of interest and experience within the medical professional itself, in the government, in labor and in management. This fact should be borne in mind in all discussions of postwar medical planning.

PROFESSIONAL RELATIONS

During the year the field program of the Council has carried its representatives to all of the most important industrial states. Although many of the collaborating state and county medical society committees are inactive for a variety of causes, in some areas the response to the Council's recommendations has been most encouraging. Efforts to develop demonstration centers in which industrial health service, particularly for small plants, could be developed on a cooperative basis between local medical organizations and local manufacturers have been favorably received in a few localities. Discussions about the support of such projects have occurred with the Kellogg Foundation. The growth of industrial health depends on good local and state medical leadership. Further improvement in this direction is of paramount importance and must always constitute a major share of the Council's activities.

The interest of specialty groups in the medical requirements of industry and of the employed population needs encouragement. The obvious approach has been through committees already appointed by most of the sections of the Scientific Assembly and through them to other allied professional organizations. Excellent contributions have been made in the fields of industrial dermatology, ophthalmology and obstetrics and gynecology. The Council expects to develop a series of con-

ferences on pertinent topics in conjunction with these special committees. Two under consideration relate to the control of industrial noise and of illumination in the working environment, to be sponsored by the committees on industrial health in the appropriate sections. A series of reports is currently in preparation under the general title of "Surgical Principles in Industry," and the Industrial Health Committee in the Section on Practice of Medicine is sponsoring a report on "Heat Sickness." Another proposed conference will discuss the subject of case finding in industry with particular reference to chest surveys. It is planned to invite representation from the Section on Radiology, from the Committee on Industrial Tuberculosis recently created by the National Tuberculosis Association and from the U. S. Public Health Service. These developments suggest the many ways in which the Council can bring special information and facilities to bear on industrial health problems.

The American Dental Association has recently organized a Committee on Industrial Dentistry attached to its Council on Dental Health. The Secretary of the Council has been invited to act as a consultant to this committee, and it is expected that there will be many opportunities for mutually helpful activity.

The Council continues to recognize the growing importance of the industrial nurse. During the year a report entitled "Standing Orders for Nurses in Industry" was prepared and widely distributed as a means of improving the professional status of the industrial nurse and defining her relations with supervising medical authority, management and the worker. About ten thousand reprints of this publication have been distributed, mainly on specific request from interested agencies and individuals. Hundreds of individual requests have come from the industrial nurses themselves. Some form of official liaison between the Council and the official nursing organizations interested in industrial health is now being considered.

PROFESSIONAL EDUCATION

Attendance and diversity of interest at the annual congresses on Industrial Health have steadily improved. The proceedings of these congresses as published each year in the Industrial Health Number of THE JOURNAL and as separately reprinted are in steady demand. These meetings represent one of the most effective educational accomplishments of the Council.

A resurvey of the existing status of medical education in the industrial health field has just been completed. Since the Council has interested itself in the matter, the average number of hours of required lectures in the undergraduate curriculum has nearly doubled. Better provision of clinics, demonstration material and bedside instruction, as well as improved integration of industrial etiology in all clinical teaching, are the most essential needs. Short courses of the introductory or refresher type continue to be held under the auspices of medical schools, state medical societies and in combination. The Council has been greatly interested in the current plans for the development of a certifying board in the field of industrial health.

To intensify interest in the educational problems of industrial health both as such and in relation to the whole field of preventive medicine, the latest congresses on Industrial Health and on Medical Education and Licensure were conducted together. This experiment merits further exploration and repetition. Active participation by the Council on Medical Education and Hospitals will be requested in these and all other details of professional preparation for industrial health service.

Inquiries received from many sources about industrial health activity and procedure are steadily increasing. This clearing house function is becoming a real factor in the Council's informational and educational program. Cooperation from many authorities makes this service possible.

OTHER INTERESTED AGENCIES

The Council continues to foster close working relations with management, labor, insurance and governmental agencies. These contacts are useful, not solely as a means for broadcasting the health and economic advantages of industrial health services, but as unusually promising experiments in the field of public relations. The education of management will, whenever possible, be undertaken in conjunction with the special agencies already set up in the National Association of Manufacturers and the Chamber of Commerce of the United States. Channels of information considered particularly effective will be the training courses in schools of business administration and in technical schools, direct collaboration with manufacturing groups, chambers of commerce, service clubs and trade associations, and publications reaching these agencies.

Similar procedure is applicable to the individual worker and to labor organizations as a means of support from that quarter in the development of adequate industrial medical service. Steps in that direction will be more labor participation in the Congress on Industrial Health, investigation of health education practices in union organizations, use of labor publications as a means for disseminating dependable medical and health information, and collection of data on medical and hospital services sponsored by labor organizations.

The casualty insurance companies, acting through their joint claims committee, have continued to interest themselves in maintaining some regular means for direct consultation with the Council. Two recent meetings have demonstrated many points of mutual interest in the fields of rehabilitation, industrial physical examinations, standardization of report forms, choice of physician and publication of data illustrating the status of medical relations under workmen's compensation.

Many agencies in the government have an unusual interest in industrial health. The Council has maintained lines of communication with appropriate agencies and individuals in the Army, Navy, Veterans Bureau, Selective Service, the U. S. Public Health Service, the U. S. Maritime Commission, the War Manpower Commission, the Federal Security Agency and the U. S. Civil Service Commission. Representatives from a number of these agencies have participated in the meetings of the Council. The Secretary of the Council on Industrial Health has recently been invited to sit on the Rehabilitation Advisory Council of the Office of Vocational Rehabilitation, Federal Security Agency. Steps are also being taken to keep informed about developments in the newest field of occupational medicine —aviation.

INDUSTRIAL HEALTH EDUCATION

A report has been formulated representing the best opinion of the Council and of the Bureau of Health Education regarding means for bringing to the industrial worker a realization of the benefits of good health and the necessity for assumption of some personal responsibility therefor. This whole field needs much exploration. The Council believes that the use of HYGEIA represents an unusual opportunity for the furtherance of this kind of program and will request the editor of that publication to arrange for the inclusion of material regularly which can be reproduced as health posters for wide distribution in industry.

INDUSTRIAL PHYSICAL EXAMINATIONS

A report on industrial physical examinations has been completed and widely distributed. This early phase of the Council's activity in this field will shortly be supplemented by additional material to include an outline for physical examination of women, examination of the cardiovascular system, examination of the eyes and the establishment of physical, mental and neurologic levels as aids to personnel departments and supervisors in the placement of workers in suitable occupations.

The Council has authorized its Committee on Physical Examinations to establish at the earliest convenient time contact with labor and other interested organizations with a view to discussing the whole problem of preplacement physical examinations in industry. This procedure is considered particularly important at the present time because of the necessity for reemployment in industry of disabled veterans.

Industrial physical examinations inevitably uncover many conditions needing medical attention. The Council is formulating recommendations calculated to promote cooperation between industrial physicians, private physicians and community health facilities so that these problems may be given adequate medical attention at the earliest opportunity.

WORKMEN'S COMPENSATION

The Council's interest in the special problems associated with workmen's compensation is expanding considerably. As in the past, particular attention will be paid to the preparation of

reports about trauma and disease, disability evaluation and individual occupational injuries and diseases. Discussions of medical relations under workmen's compensation are now a regular and successful feature of the annual congresses on Industrial Health. Recently contact has been established with workmen's compensation administrators through the officers and directors of the International Association of Industrial Accident Boards and Commissions. It is now proposed that the Council, through its Committee on Workmen's Compensation, apply for associate membership in that organization. A manual on workmen's compensation administration for physicians is in the planning stage and will emphasize prevention and rehabilitation as well as administrative details. Cooperation from the Bureau of Legal Medicine and Legislation and the Bureau of Medical Economics is especially needed and regularly invited. In furtherance of these plans an informal conference is being planned by the Committee on Workmen's Compensation to which interested and influential authorities will be invited.

RESEARCH AND REPORTS

The treatment of silicosis with aluminum, the derivation and extent of pulmonary sarcoid in the industrial population and the pseudonodulation found in welders are matters of current investigation by the Council's Committee on Research and Reports. Cooperation by roentgenologists and pathologists in the accumulation of dependable data along these lines is being organized.

The Council on Industrial Health and the Council on Pharmacy and Chemistry, acting jointly, have completed a preliminary report on "The Local Treatment of Burns," which is in process of revision for final approval and publication.

NUTRITION IN INDUSTRY

The Council continues to act in conjunction with the Council on Foods and Nutrition as a means of making available to physicians and industry pertinent information about essential components in the diets of American workmen, administration of vitamin concentrates by industry, the protective value of specific vitamins in specific occupational exposures, means of increasing the caloric diet of workers in heavy industry under rationing regulations and the evaluation of standards of inplant food preparation and service.

REHABILITATION

A Committee on Rehabilitation has been created containing representation from the Council on Industrial Health and the Council on Physical Therapy. It has recently presented resolutions to the Board of Trustees calling attention to the fact that many factors in rehabilitation are essentially medical in nature, that programs in the Army, Navy, Veterans Administration, Federal Security Agency and Selective Service must be expected to have profound influence on certain forms of medical service and that the profession should be as widely acquainted as possible with developments in this field. This joint committee will conduct an educational service, acting through state, local and special medical societies, about methods and procedure essential to the reestablishment of disabled individuals in employment. To facilitate this form of activity the Council has recently created committees on Medical Participation in Rehabilitation and on Postwar Industrial Health Planning. An exhibit on rehabilitation is being sponsored by the Council on Physical Therapy and the Council on Industrial Health as a first step in this educational activity.

INDUSTRIAL MEDICAL SERVICE PLANS

The widespread interest of management and labor in general medical coverage for industrial workers and their dependents strongly suggests the accumulation of as much information as possible about methods already in operation. Results of this investigation will be jointly evaluated by the Council and the Bureau of Medical Economics.

Summary

Interest and experience in industrial health is developing at a rapid pace, and the Council through its educational and field services is attempting to keep the profession well informed. State and local medical societies must recognize this trend and must create effective machinery to cope with these problems. Medical educators are more attentive to the need for special training in this field, but much additional effort is needed in this direction. Progress will be accelerated with assistance from the Council on Medical Education and Hospitals.

The Council is mobilizing undeveloped resources for special investigation and information through committees and consultants, mainly derived from the sections of the Scientific Assembly. Closer relations with labor, with management and with official agencies provide means for the dissemination of helpful information about industrial health. The same procedure has excellent potentialities in the field of public relations.

The Council, in company with the Bureau of Health Education, has considered practical measures for teaching personal hygiene to workers. The use of Hygeia for this purpose has been recommended. The fundamental basis for all preventive medical service in industry is the physical examination. The Council has prepared an outline for this procedure, soon to be augmented by additional recommendations regarding women, the eyes, the cardiovascular system, hernia and so forth.

A program of research into a number of occupational exposures is currently under way. The neglected field of medical relations under workmen's compensation is undergoing close scrutiny. Special attention is being paid to the establishment of regular means of consultation between the Council, workmen's compensation administrators and casualty insurance companies.

Special projects with other agencies in the American Medical Association are a report on burns with the Council on Pharmacy and Chemistry, an investigation of industrial medical service plans with the Bureau of Medical Economics, and reviews of the status of industrial nutrition with the Council on Foods and Nutrition. Particular attention is being directed at the rapidly growing field of rehabilitation and reemployment of the disabled in industry. A joint Rehabilitation Committee has been set up in company with the Council on Physical Therapy to promote an educational campaign throughout the profession to acquaint physicians with developments in this field and the need for maintaining high standards of professional conduct and procedure.

Bureau of Health Education

Difficulties growing out of the prosecution of the war resulted in curtailment of some of the activities of the Bureau of Health Education. Depletion of office personnel, restrictions on travel and other conditions interfered with certain phases of the Bureau's operations. However, new developments and demands engaged the active attention of the Bureau and resulted in some changes in the working program and in the scope of its operations, so that the year was a very busy one.

CORRESPONDENCE

A sharp reduction occurred in all classes of Bureau mail. Signed correspondence with doctors and cooperating agencies dropped from 3,993 in 1942 to 2,724, question and answer correspondence from 8,283 to 5,800, letters requesting free material for use in health education from 890 to 517. No effort at all was made to get radio audience mail, both because of personnel shortages and because of paper restrictions, but the number of inquiries received in 1943 was larger than in 1942. The total volume of mail declined by a little more than 50 per cent. Almost the only class of mail that held up to previous years was that originating at the Cleveland Health Museum, the Chicago Museum of Science and Industry and miscellaneous fairs and exhibitions where "question boxes" were installed some time ago. A new "box" was placed in the Newark, N. J., Health Museum in 1943.

PUBLICATIONS

The Director of the Bureau prepared forty-seven book reviews and sixty other items for Association publications. Twenty-three articles were provided for publication in other periodicals.

RADIO

The first radio broadcast series under the title "Doctors at War," begun in December 1942, was completed in June 1943. This was the eighth consecutive year of coast to coast network dramatized broadcasts. The National Broadcasting Company furnished the radio time gratis, as usual, on approximately seventy-five stations coast to coast and contributed liberally to production costs. Distinguished guest speakers included highest ranking medical officers of the Army, the Navy, the United States Public Health Service and the Army Air Force and physicians from civilian life. The program closed with an international broadcast at which, through the generosity of the National Broadcasting Company, it was possible to present by direct short wave transmission the chief medical officers of the Army in North Africa and in England, the highest ranking Navy medical officers at Pearl Harbor and the commanding officer of the Navy hospital at Great Lakes, Illinois. The second series of "Doctors at War" was postponed until Jan. 8, 1944.

The use of the radio script service maintained by the Bureau for local broadcasting, which showed a slight increase in 1942, dropped off greatly in 1943; 1,746 scripts were distributed, as compared with 2,660 in the preceding year. One state association and thirty-seven county societies used the service. Six county medical societies used this radio material for the first time in 1943. Owing to decreased use of the five minute talks, these were discontinued.

Depletion of the ranks of medical societies and loss of full time secretaries has interfered with local medical broadcasting at a time when such broadcasts by the medical profession are of exceptional importance. The Bureau therefore recommended the preparation of electrical transcriptions in 1942 and was authorized by the Trustees to undertake an experiment along this line in 1943. The making of radio transcriptions was begun in conjunction with local broadcasts over WLS, the Prairie Farmer station, Chicago. Three series of broadcasts were made on this station under the titles "Before the Doctor Comes," "Summer Health Hints" and "Dodging Contagious Diseases." The series "Before the Doctor Comes" and the series "Dodging Contagious Diseases" were recorded.

"Before the Doctor Comes" is a series of sixteen ten-minute interviews, which are shipped out with instructions about adding material locally to make fifteen-minute broadcasts with music. The series "Dodging Contagious Diseases" consists of twelve interviews, also of ten minutes each, sent out with similar instructions. In addition, eight recordings were made of a series first entitled "American Medicine Serves the World at War" and then retitled "Medicine Serves America."

Distribution of the transcriptions was begun July 1. The sets were used thirty-five times in 1943, and the users included state, city and county health departments, state and county medical societies, public schools, state universities, woman's auxiliaries, Y. M. C. A.'s and a Civilian Defense Council.

The contagious disease series was recorded for 1944 use and has therefore had no circulation as yet.

At the Chicago meeting of the House of Delegates of the American Medical Association two local broadcasts were arranged, plus one network broadcast each on the National Broadcasting Company, the Columbia Broadcasting System, the Blue and the Mutual Broadcasting Company networks. Talks prepared for broadcasting for which no radio time was secured were recorded and made part of the series "Medicine Serves America."

The Director of the Bureau delivered two radio talks over local stations outside of Chicago while on speaking trips.

MEETINGS AND CONFERENCES

The Director and Assistant Director traveled 25,282 miles to address audiences or attend meetings in twelve states.

Opportunities for speakers have declined as a result of the war. Difficulties of travel have not in themselves prevented acceptance of invitations, but recognition of such difficulties has undoubtedly dried up many invitations at their source. The total number of appearances was 127, the attendance 26,730.

In addition, the Director participated in thirty-eight conferences and meetings.

HYGEIA CLIPPING COLLECTIONS

The use of HYGEIA loan collections of clipping material by local physicians decreased from 265 to 103 loans in thirty states. The principal topic called for among available loan collections was "outstanding medical advances."

HEALTH PUBLICATIONS

All the Bureau's health publications during the year were kept under careful scrutiny by reason of the paper quota. The distribution from stock in 1943 was 176,859, plus 67,600 HYGEIA reprints in specially printed lots. This total of 244,459 represents a decline of practically 33 per cent from the high point of distribution in 1942. It is only a small reduction from the 272,211 distributed in 1940. Many of these pamphlets are purchased for use in schools and are read by many persons.

Three thousand copies of "Gonorrhea—The Tragicomedian," by Greer Williams, and 3,000 catalogues of health publications were given to the American Social Hygiene Association to be included in packets which it distributes as program aids for local agencies sponsoring Social Hygiene Day meetings each February.

Eighteen new titles were added to the Bureau publications during the year, ten were discontinued and one was revised.

The health posters developed from 1938 to 1940 continue to be in demand. In 1943 1,050 sets were sent out, making a total of 6,128 sets distributed since 1938.

COOPERATIVE RELATIONSHIPS

Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association.—Owing to wartime situations no meeting of this committee was held in 1943, but the committee had a meeting in March 1944 at the American Medical Association headquarters building.

The term of Dr. A. J. Chesley as a member of the committee expired July 1, 1943. The Board of Trustees appointed him to succeed himself for a five year term.

Representing the American Medical Association on the committee as now constituted are Dr. Thurman B. Rice, Indianapolis; Dr. George M. Lyon, Huntington, W. Va., now in active service with the U. S. Navy; Dr. Glenville Giddings Jr., Atlanta, Ga.; Dr. W. W. Bauer, Chicago, and Dr. A. J. Chesley, Minneapolis.

U. S. Children's Bureau Advisory Committee.—The Advisory Committee to the U. S. Children's Bureau did not meet at all in 1942. Its first meeting in 1943 was on April 6, making a lapse of sixteen months since the meeting of Dec. 1-2, 1941. At the meeting on April 6 the committee was presented with the following mimeographed materials:

(*a*) A two page mimeographed circular dated March 29, 1943 giving a general outline of the regulations governing allotments to states for Emergency Maternal and Infant Care for the Wives and Infants of Enlisted Men in the first four pay grades.

(*b*) An eighteen page mimeographed circular containing detailed regulations for obstetric and infant care under the emergency program, together with information as to the amounts available for the several states under the plan and proposed forms for applications, requests for authorization and authorizations under the plan.

(*c*) A publicity release dated March 26, 1943 describing and urging the use of the plan.

(*d*) An eight page mimeographed circular describing the purchase of hospital care under Crippled Children's or Maternal and Child Health Program.

At this meeting the committee was informed that discussion of the plan as outlined in the mimeographed material was desired and individual suggestions from members of the committee were requested, but its members were not to submit any resolutions or any votes representing the committee's group opinion. In the discussion a great many objections were offered to items in the regulations. Some minor modifications were made after the meeting.

The next meeting of the Advisory Committee was held at Washington, October 21, for further consideration of the regulations. The Bureau of Health Education telegraphed twenty-four state medical societies in various parts of the United States for a statement of their attitude toward the program. Replies received are summarized as follows:

There is no division of opinion with respect to the desirability of providing generously for all the needs of the families of service men whose pay grades render government assistance necessary. In recognition of this principle, the House of Delegates of the American Medical Association, at its Chicago meeting in June 1943, approved the action of the federal government in making funds available for maternity and infant care for the wives and infants of enlisted men.

There is room for honest difference of opinion as to administrative methods. The resolution passed by the American Medical Association House of Delegates does not approve of a plan whereby service in kind is rendered to the wives and infants of service men, believing such service to be needless and undesirable because it is not in accord with the American system of medical practice. Most members of the medical profession believe that cash allotments should be made for obstetric care and infant care for the wives and children of service men in the same manner as cash allotments are made to the wives and children of service men for other necessities of life; some doctors hold the opposite view.

At this meeting many of the medical representatives on the committee, including the Director of the Bureau of Health Education, raised objections to many phases of the Children's Bureau plans, especially to the provision for paying doctors and hospitals direct, thus in effect making them state employees. Among those who registered opposition at this meeting were a number who had consistently supported the Children's Bureau in previous meetings of the committee. The Advisory Committee to the Children's Bureau, since its establishment in 1935, has included a number of distinguished obstetricians and pediatricians who have consistently supported the Children's Bureau. Some of these now give evidence of a change of opinion. Many of the members of the committee are nonmedical persons from the field of social service work. The physicians on the committee have been largely men in public health or full time professorial positions rather than practicing physicians. Membership on the committee is on an individual basis. Although the Director of the Bureau of Health Education was chosen with the approval of the American Medical Association, it has been made clear that he is not there as a representative of the American Medical Association.

The Children's Bureau is free to take or leave the advice of the Advisory Committee. It has taken advice on many minor and some major points of procedure, but it has not yet reversed or deviated from any of its fundamental policies, even when disapproval was manifest in the committee. There has not been any formal action by the committee opposing any of the fundamental policies of the Children's Bureau. The medical members of the committee are not unanimous, and those who oppose the fundamental features of the Children's Bureau policies do not constitute a majority.

Following the October meeting the principal changes which were made in response to recommendations from the Advisory Committee were as follows:

(*a*) The Children's Bureau agreed to appoint not less than five new members, all to be physicians *in the private practice of medicine.*

(*b*) The Children's Bureau agreed to revise its regulations to provide more fair, flexible and adequate compensation for physicians, especially with relation to the treatment of intercurrent disease complicating but not due to the pregnant state.

Following the meeting of the Children's Bureau Advisory Committee the annual meeting of state medical society secretaries and editors was held at the headquarters of the American Medical Association on November 19 and 20. Dr. Edwin F. Dailey of the U. S. Children's Bureau was present. There was frank discussion of the plan and criticism of the Children's Bureau, especially with respect to inadequate publicity through medical channels, about the work and purposes of the Bureau (THE JOURNAL, Jan. 22, 1944, p. 172). Just prior to this meeting the executive board of the American Academy of Pediatrics had adopted a resolution calling on the Children's Bureau to arrange a conference between the Children's Bureau and official representatives of medical organizations, hospitals and the interests of soldiers.

On December 10 and 11 a meeting was held in Washington in response to the request of the American Academy of Pediatrics. The following organizations were represented by the persons named:

American Medical Association: Dr. A. W. Adson, Rochester, Minn.; Dr. R. L. Sensenich, South Bend, Ind.
American Hospital Association: George Bugbee, James Russell Clark.
U. S. Public Health Service: Dr. L. R. Thompson, Washington, D. C.; Dr. Joseph Mountin, Washington, D. C.
American Association of Obstetricians, Gynecologists and Abdominal Surgeons: Dr. M. P. Rucker, Richmond, Va.; Dr. J. B. Jacobs, Washington, D. C.
American Academy of Pediatrics: Dr. Stanley Nichols, Asbury Park, N. J.; Dr. Joseph S. Wall, Washington, D. C.
Association of State and Territorial Health Officers: Dr. Edward S. Godfrey, Albany, N. Y.; Dr. Felix J. Underwood, Jackson, Miss.
American Pediatric Society: Dr. Wilburt Davison, Durham, N. C.
American Gynecological Society: Dr. George Kosmak, New York.
Committee of Physicians for the Improvement of Medical Care: Dr. Robert L. DeNormandie, Boston.
War Department Dependency Board: Major Gen. Roger W. Eckfeldt.
Bureau of Naval Personnel: Capt. J. L. Reynolds.
Office of Surgeon General, War Department: Major Margaret Craighill.
Army Emergency Relief: Mr. R. C. Branion.
Navy Relief Society: Admiral J. O. Richardson; Miss Lucia Murchison.
American Red Cross: Dr. G. Foard McGinnes, Nashville, Tenn.
American Legion: Mr. Milt Campbell.

The following members of the Advisory Committee to the United States Children's Bureau also were present:

Dr. Sterling H. Ashmun *
Dr. W. W. Bauer
Dr. Edward M. Davis
Dr. Wilburt C. Davison
Dr. Robert L. DeNormandie
Dr. Nicholson J. Eastman
Dr. Clifford G. Grulee
Dr. Elinor B. Harvey *
Dr. George Kosmak
Dr. Joseph I. Linde
Dr. John Z. Preston *
Nathan Sinai, Ph.D.
Dr. George S. Stevenson
Dr. Felix J. Underwood
Dr. Joseph S. Wall
Dr. Philip F. Williams
Dr. Harvey F. Garrison *

* The names starred are the names of new members of the Advisory Committee, appointed in response to the demand initiated by a number of members of the Advisory Committee, at its last meeting, Oct. 21, 1943.

In addition there were present the following representatives of various organizations which maintain Washington representation:

National Women's Trade Union League: Elisabeth Christman.
National Board Y. W. C. A.: Mrs. James B. Irwin.
National Congress of Parents and Teachers: Mrs. C. D. Lowe.
General Federation of Women's Clubs: Mrs. Harvey Wiley.
Women's Christian Temperance Union: Elizabeth Smart.

The meeting was opened with a statement by Dr. Eliot and Miss Lenroot and by the introduction of all the official representatives present. The American Academy of Pediatrics, in the person of its representative, Dr. Joseph S. Wall, was called on to present and explain its resolution, and the representatives of all the organizations listed were then called on to express their views, after which the meeting was thrown open to general discussion.

Out of the two day session came the following results:

1. On the issue of cash allotments vs. a series program, the position of the Children's Bureau was sustained by the overwhelming opposition of all groups represented, except the American Medical Association, to the use of cash allotments in this program. Reasons for opposing cash benefits were advanced particularly by Captain Reynolds on behalf of the Navy, Miss Murchison on behalf of Navy Relief, and Major General Eckfeldt for the War Department Dependency Board. These reasons are as follows:

(*a*) The majority of young women applying for dependency benefits or for the EMIC service are in their teens and by reason of age, inexperience and confusion are incapable of intelligently handling considerable sums of cash.

(*b*) Most of the mothers and infants are living away from home and would be unlikely to get as good medical care through their own efforts as through the Children's Bureau program as set up.

(*c*) Many of the cash allotments, if made, would be spent for purposes other than medical care and hospitalization.

(*d*) It appears to be the plain intent of Congress that these funds are to be used for service and not be distributed as cash allotments.

(*e*) Cash allotments would favor the employment of unqualified practitioners as a result of the youth and inexperience of the prospective mothers, or mothers of young infants.

NOTE.—At this point representatives of the American Medical Association made it clear that, having been outvoted in their stand for the principles adopted by the House of Delegates, they participated in the remaining discussions in the spirit of cooperation expressed by the House of Delegates in its endorsement of the objectives and purposes of the program, reserving the right to continue to differ with the method of administration.

2. The question of whether a prospective mother should be allowed to pay her doctor an additional fee, especially in the case of employment of specialists whose normal fees are above

the scale established in the EMIC plan, was decided in the negative, namely that a physician accepting a case under the plan would not be allowed to accept supplemental fees from or on behalf of the patient. This raised the question of:

3. Additional payment for services rendered other than obstetric complications and such minor illnesses as would more or less be routinely cared for by the obstetrician in normal obstetric practice.

Fees for consultation are already encompassed in the plan, but many doctors, especially in rural regions, would perform services themselves to their obstetric patients requiring surgery, medical treatment of intercurrent diseases not related to pregnancy or accidental injuries. For these services it was recommended by the conference that the Children's Bureau establish a schedule of supplementary fees to be paid to the attending physician under the circumstances herein outlined.

4. It was also recommended that the entire schedule of fees, representing the maximum fees to be allowed for certain services, be reviewed by the Children's Bureau in the light of the preceding actions.

5. With respect to the question of whether a patient should be allowed to pay and a hospital to accept supplemental payment from the patient or on her behalf for accommodations of more expensive type than provided under the plan, it was decided in the negative, namely that no such supplemental payments should be made or accepted.

NOTE.—The action represented in paragraphs 2 and 5, dealing respectively with supplemental payments by the patient to the doctor or to the hospital, was based on the consensus of the group that it would be a protection to the doctors and hospitals against any misunderstandings which might be interpreted to indicate unfair bargaining on the part of the hospital or the doctor and would tend needlessly to complicate the program and create avoidable misunderstandings.

6. A very clear statement was made by a number of physicians representing the American Academy of Pediatrics and the American Medical Association, and by some medical members of the Advisory Committee, to the effect that physicians, while concurring in the purpose of the program to render service to and free from anxiety the families of servicemen, wished it understood that they are aware of the potentialities of this program as a possible trial balloon, bridgehead or entering wedge looking toward the extension of medical service in point of time beyond the duration of the war and in breadth of scope, both as to kinds of service and as to groups served. They served notice on the Children's Bureau that they would wholeheartedly cooperate with the program for servicemen's families for the duration but not beyond. In response, officials of the Children's Bureau stated that the program was carried on under the authority of the Social Security Act, but under temporary appropriations visualized as national defense appropriations and therefore terminating six months after the peace. As to what they might advocate after the peace, officials of the Children's Bureau refused to be committed. Miss Lenroot stated specifically that after the peace there would be opportunity for any group to advocate any kind of program, conservative or liberal, which it might choose. Dr. Eliot stated that the EMIC program as it stands was an outgrowth of the emergency, was undertaken in response to a request from an Army general at Fort Lewis, Washington, and that it was not a part of any "master plan" of which she knew.

Following this meeting the Children's Bureau issued a revised set of regulations which were published in THE JOURNAL, Jan. 22, 1944.

Contained in title V of the Social Security Act is authorization for experiments and demonstrations in medical care. It was this authorization which permitted the Children's Bureau to start the Washington state health department on an experimental program in emergency medical and infant care for servicemen's wives and children in the vicinity of Fort Lewis. This is cited by the Children's Bureau as its legislative authority for starting new programs. Existing funds can be and are being used, but when the program grows very large as in the EMIC situation, additional appropriations are necessary.

A program for the care of rheumatic children now being developed is based on this same authority in title V of the Social Security Act. This was extensively discussed at a meeting on October 6 and 7 by a group including representatives of many public health agencies and also including the Advisory Committee to the Children's Bureau. In approximately twelve states demonstrations in the care of rheumatic fever patients are being carried out through maternal and child health divisions of the state health departments. Presumably this program may be extended by adopting it in other states. At present it is limited to the care of those who are not able to procure treatment privately. It would appear that the Children's Bureau considers medical treatment to be an integral part of public health service in many circumstances. Extension of the rheumatic fever program to other states and to broader population groups is a logical step in the extension of federalized medicine by those who believe that such procedures are in the public interest.

National Committee for Boys and Girls Club Work.—This work proceeds routinely, with nothing of particular interest to report in 1943.

National Congress of Parents and Teachers.—This work also proceeds routinely in accordance with trends established and reported in previous years. Wartime scarcity of doctors and dentists has caused the program to be modified in many communities.

Other Organizations.—The following organizations, on which the Director represents the American Medical Association, did not call on the Bureau for aid during the year, but the relationship is not officially discontinued:

Advisory Board, American Camping Association.
Committee on Public Health, American Film Center.
Advisory Committee, Community Nursing Service, National Organization for public Health Nursing.

The National Health Council Committee for the Study of Voluntary Health Agencies met in New York on October 13 during the meeting of the American Public Health Association. Preparation of the report is under way. The most important question raised in the committee meeting was whether professional agencies like the American Medical Association, the American Dental Association and similar groups should be regarded as voluntary health agencies. The Director took the position that if the medical profession is not a health agency there can be no such thing as a health agency. After some discussion it was decided to include the most important professional organizations, as far as possible, in the study. Accordingly, Miss Anna B. Towse, a field investigator for the committee, spent approximately five days at the headquarters of the American Medical Association interviewing the General Manager, the Editor and department heads.

There was no meeting of the National Conference for Cooperation in School Health Education in 1943, but the Executive Committee met during the meeting of the American Public Health Association in New York in October. The principal discussion at this meeting had to do with procuring financial aid for the functioning of the conference. As yet nothing definite has been done.

The Director continues to be active in the affairs of the American Public Health Association. He was elected to the Governing Council of the American Public Health Association for a three year term expiring in 1947. He is a member of the subcommittee on Accident Prevention of the American Public Health Association Committee on Administrative Practice. He is chairman of the Health Education Section's Committee on Health Education in Hospitals, Outpatient Departments and Clinics.

The United States Office of Education called a special meeting of a subcommittee on methods of preparing teachers in science studies, home economics and other related fields to serve as health instructors during the emergency. This committee prepared and submitted a technical report which was accepted by the United States Office of Education and the committee was then disbanded.

The United States Office of Education and the W. K. Kellogg Foundation invited the Director to participate in a committee

to study ways and means of extending to other states the Michigan plan of coordinating health education in high schools. Thus far the procedure has progressed only to the point of studying possible methods and costs of extending the Michigan plan of coordinated health education in secondary schools to other states through the United States Office of Education with Kellogg funds.

Agencies of the United States government with which the Bureau has cooperated or to which the Bureau has furnished information during the year are as follows:

Federal Security Agency: Office of Education; Public Health Service; Office of Defense Health and Welfare Service; National Negro Health Movement.

War Department (U. S. Army): Office of Surgeon General, U. S. Army; Bureau of Public Relations; Liaison Office, War Department and A. M. A.; Office of Technical Information; Sixth Service Command, Chicago; Army Service Forces, Washington; Office of Chief of Ordnance, Chicago; Civil Affairs Division.

Office of War Information: Navy Department: U. S. Naval Air Station, Pensacola, Fla.; Ninth Naval District, Great Lakes, Ill.; Naval Medical Research Institute.

Department of Agriculture: Extension Service, Washington; Farm Security Administration, Washington; Farm Security Administration, Dallas, Texas.

Department of the Interior: Office of Indian Affairs, Denver.

Post Office Department.

War Food Administration: Division of Marketing Reports.

Coast Guard, Alameda, Calif.

Department of Commerce: Bureau of the Census.

Office of Coordinator of Inter-American Affairs.

OTHER AGENCIES

United States Chamber of Commerce.

Pan American Sanitary Bureau.

MISCELLANEOUS

The Bureau continued to compile information on protection of medical research but was not called on for any work along this line except the routine distribution of information to combat the activities of the antivivisectionists.

The Director evaluated and criticized three manuscripts submitted by graduate students and candidates for advanced degrees.

The Director served on the Chicago Nutrition Committee and also on the Committee on Health Education of the Council of Social Agencies of Chicago.

In accordance with a resolution adopted by the House of Delegates in 1943 the Bureau has endeavored to assist associations of biology teachers who wish to use the Association's resolutions recommending the teaching of biology in high schools. As yet there have been few requests for implementation of this resolution. This matter was discussed at the meeting of the Joint Committee of the American Medical Association and the National Education Association.

In accordance with authorization from the Board of Trustees the Bureau continued to offer its facilities and those of related Association bureaus for the use of visiting graduate students. This service, inaugurated in 1942, was used by only one student during that year. In 1943 one individual student participated in a two weeks course and a group of twenty-nine postgraduate students in health education from the University of North Carolina spent a week at the Association headquarters, arrangements having been made by the United States Public Health Service. These students were being trained under a W. K. Kellogg Foundation grant.

The following letter was received from the United States Public Health Service after the termination of the week's work:

The Public Health Service is very grateful to the American Medical Association for the week of intensive instruction and experience provided its fellows in health education who are taking their academic work in the University of North Carolina. We are particularly grateful to Dr. Bauer for the generous amount of time and effort he gave to the planning and carrying out of the program, because it could only mean an added responsibility to an already crowded work program.

All of the fellows were amazed at the amount of time and attention that was so freely given them. They especially mentioned their interest in learning of the variety and intensity of work carried on by the American Medical Association for the protection and welfare of the general public.

We should appreciate it if you would also convey our gratitude to Miss Waller, Mr. Poole, Dr. Carey and all the others who contributed to the success of the program for the fellowship students.

Very truly yours,
WARREN F. DRAPER,
Acting Surgeon General.

Seven representatives of various South and Central American countries were entertained and the work of the Association demonstrated to them over a period of four days at the request of the Pan American Sanitary Bureau. Arrangements also were made for these visitors to see other medical facilities in Chicago.

The surgeon general and the assistant surgeon general of the army of the republic of Chile were entertained for three days at the request of the Office of the Coordinator of Inter-American affairs.

Summary

Wartime conditions, especially personnel difficulties, greatly curtailed the work of the Bureau in 1943.

Correspondence dropped from 25,310 letters in 1942 to 11,259, but 80 per cent of this reduction is explained by the total absence of radio "fan mail," which was not solicited during the year.

The Bureau prepared forty-seven book reviews for The Journal and Hygeia and made sixty other contributions to these publications, besides originating twenty-three articles published in other periodicals.

A nationwide dramatized radio broadcasting program in cooperation with the National Broadcasting Company was carried out under the title "Doctors at War," with high ranking medical officers of the Army, Navy, Public Health Service and Air Force and distinguished physicians from civilian life as guest speakers.

Electrically transcribed radio programs for local use were prepared as follows: "Before the Doctor Comes," sixteen broadcasts; "Dodging Contagious Diseases," twelve broadcasts; "Medicine Serves America," eight broadcasts. These were used thirty-five times locally in the last six months of 1943 by state, city and county health departments, state and county medical societies, public schools, state universities, woman's auxiliaries, Y. M. C. A's. and a Civilian Defense Council.

Radio broadcasting, local and network, was arranged as usual during the Chicago meeting of the House of Delegates.

The Director delivered 127 addresses in twelve states, with a total attendance of 26,730 persons.

Hygeia clipping collections were lent to 103 local physicians in thirty states for use in preparing talks to lay audiences.

The Bureau distributed 224,459 copies of its pamphlet publications; eighteen new titles were added to the list, ten discontinued and one revised.

Health poster sets numbering 1,050 were sent out in 1943, making a total of 6,128 sets of posters distributed since 1938; these posters were developed on the basis of Hygeia cover plates.

The Bureau participated in cooperative work with the following organizations: Joint Committee on Health Problems in Education, with the National Education Association; Advisory Committee on Maternal and Child Health, with the U. S. Children's Bureau; National Committee for Boys and Girls Club Work; National Congress of Parents and Teachers; National Health Council Committee for the Study of Voluntary Health Agencies; National Conference for Cooperation in School Health Education; American Public Health Association; United States Office of Education; W. K. Kellogg Foundation.

The Bureau cooperated with or furnished information to twenty-eight United States government agencies in 1943.

An important activity of the Bureau was its arrangements for entertaining and instructing visitors. The principal group during the year consisted of twenty-nine trainees in health education doing postgraduate work at the University of North Carolina under the direction of the U. S. Public Health Service and the sponsorship of the W. K. Kellogg Foundation. These twenty-nine young women, together with a supervisor from the U. S. Public Health Service, spent a week at

the American Medical Association headquarters studying the work of the Association in general and its contributions to health education in particular. In addition, one individual student from the North Dakota State Department of Health spent a week with the Association for the same purpose. A group of South American physicians visiting the United States under the sponsorship of the Pan American Sanitary Bureau was shown the courtesies of the headquarters and put in touch with other medical facilities in Chicago, as were two medical officers of the army of the republic of Chile, sent to us with a guide by the Office of the Coordinator of Inter-American Affairs.

Bureau of Legal Medicine and Legislation

Since the report of last year, Mr. George E. Hall Jr., a member of the Bureau staff, has been inducted into the Army. For the last six months of 1943 the Director of the Bureau served also as the Acting Secretary of the Council on Medical Service and Public Relations, pending the selection of a permanent secretary.

POSTWAR MEDICAL LICENSURE

Many recent graduates of medicine are being inducted into the Medical Corps of the Army and Navy prior to licensure. Some of these physicians will remain in service a number of years and on discharge will face the problem of meeting state licensure requirements. The examination requirements, basic science as well as medical, may present considerable difficulty in view of the lapse of time since graduation. Legislation has already been introduced in one state, Mississippi, under which the licensing agency will be authorized to license without examination all bona fide residents of the state who (1) graduated from accredited medical schools, (2) served as physicians in the armed forces of the United States and (3) were unable to apply for licensure by reason of entry into service. The medical practice acts of a few other states now contain provisions granting special consideration to former medical officers of the Army and Navy, as in Arizona, California, Illinois, Pennsylvania, Texas and Wisconsin. It seems timely to suggest that medical licensure laws be reviewed as they may apply to graduates of medicine who will return to civilian life after honorable discharge from the Army and Navy and whose licensure was prevented by entry into service.

ISONIPECAINE: DEMEROL

During the course of a congressional hearing on budget estimates for the Treasury Department, the Commissioner of Narcotics referred to a synthetic coal tar product recently appearing in limited quantities on the market in this country under the trade name of Demerol. This product originated in Germany some years ago, has a resemblance to morphine in skeleton form and effect and is, it is claimed, habit forming. In the country of its origin its use has been brought under control under opium legislation. It has been used in South America, where it is on a prescription basis. The Canadian government, the Commissioner of Narcotics reported, has asked the League of Nations to initiate procedures to place the same restrictions on the use of the drug as apply to the use of opium and its derivatives. The Commissioner of Narcotics advocated that steps be taken now to bring its use under federal control and stated that recommendation for appropriate legislation was pending before the Bureau of the Budget.

In five states, Kentucky, Mississippi, New Jersey, South Carolina and Virginia, bills have been introduced and are now pending to place the drug on a prescription basis. This state legislation, it is understood, is being promoted by the Federal Bureau of Narcotics and relates to a preparation designated as isonipecaine and defined as "the substance identified chemically as 1-methyl-4-phenyl-piperidine-4-carboxylic acid ethyl ester, or any salt thereof by whatever trade name identified." This product seems to be the same as that marketed under the trade name of Demerol. In one state, Virginia, the two designations are used in the alternative.

LECTURES ON MEDICAL JURISPRUDENCE

The Bureau in its report for last year commented on an important development in Philadelphia in the field of legal medicine in the form of an initial series of lectures arranged under the direction of the coroner and under the sponsorship of the Philadelphia County Medical Society, the six medical schools of the city, the bar association, the district attorney's office and the Philadelphia College of Pharmacy and Science. A second series of similar lectures was arranged for 1944, the program being given as a memorial to Dr. Herbert M. Goddard, the former coroner of the city and county of Philadelphia, who died last year.

The Los Angeles County Medical Association has recently scheduled a somewhat similar series of lectures, arranged by the counsel of that association. Possibly the demands of war may preclude for the present the arrangement by other medical societies of programs of this type, but it is a development that should be given thoughtful consideration, particularly by medical societies in metropolitan areas where speakers on the various aspects of legal medicine or medical jurisprudence are readily available. Periodic programs of this type, attended by members of the bar and by physicians, will result in a much needed diffusion of information in this important field.

FEDERAL LEGISLATION

During the first session of the Seventy-Eighth Congress, which convened Jan. 6, 1943 and adjourned Dec. 21, 1943, a total of 6,527 bills were introduced, including joint resolutions, concurrent resolutions and simple resolutions. Of these approximately 280 were of sufficient medical interest to warrant the preparation of abstracts for publication in THE JOURNAL. The second session of the Congress convened at noon, Jan. 10, 1944, and is in progress at the time this report is being prepared. A brief summary of the more important measures of medical interest enacted and of those still pending follows:

Female Physicians in Medical Corps of Army and Navy.—Congressional action has been completed on legislation providing for the appointment of female physicians in the Medical Corps of the Army and Navy. The law was approved by the President April 16, 1943 as Public Law No. 38, Seventy-Eighth Congress. It provides that during the present war and for six months thereafter there shall be included in the Medical Departments of the Army and Navy such licensed female physicians as the Secretary of War and the Secretary of the Navy may deem necessary, whose qualifications, duties and assignments will be in accordance with regulations to be prescribed by the Secretary. Those appointed are to be commissioned in the Army of the United States or the Naval Reserve and will receive the same pay and allowances and be entitled to the same rights, privileges and benefits as members of the Officers' Reserve Corps of the Army and the Naval Reserve of the Navy with the same grade and length of service.

Pharmacy Corps in Medical Department of Army.—On July 12, 1943 the President approved a bill to establish in the Medical Department of the Army a corps to be known as the Pharmacy Corps (Public Law No. 130). As originally introduced, this legislation proposed to eliminate the Medical Administrative Corps in the Medical Department of the Regular Army and to substitute therefor a Pharmacy Corps. As enacted, the law leaves undisturbed the Medical Administrative Corps and provides for the creation of a Pharmacy Corps to consist of seventy-two officers in grades from colonel to second lieutenant, inclusive. Appointments in the corps, with certain exceptions, will be made in the grade of second lieutenant from pharmacists between the ages of 21 and 32 years who are graduates of recognized schools or colleges of pharmacy requiring four years of instruction for graduation under such regulations and after such examinations as the Secretary of War prescribes. An officer of the Pharmacy Corps will be promoted to the grade of first lieutenant after three years' service, to the grade of captain after six years' service, to the grade of major after twelve years' service, to the grade of lieutenant colonel after twenty years' service and to the grade of colonel after twenty-six years' service. Pharmacists who were officers of the Regular Army holding commissions in the Medical Administrative Corps were

transferred to the Pharmacy Corps and commissioned "in grade in such corps."

Reorganization of Public Health Service; Codification of Laws Relating to the Service.—Legislation was transmitted to the Congress by the Federal Security Agency to effect a reorganization of the United States Public Health Service on which congressional action has been completed (Public Law No. 184). It provides that the Public Health Service shall consist of the Office of the Surgeon General, the National Institute of Health and two bureaus to be known as the Bureau of Medical Services and the Bureau of State Services. Under the direction of the Federal Security Administrator, the Surgeon General of the service is authorized to direct the assignment to such divisions of the several functions of the service and to establish such sections or units as may be requisite. The Surgeon General may, too, abolish existing divisions, sections and other units and may transfer, establish and consolidate divisions, sections and other units and reassign their functions for the efficiency of the service. Commissioned officers of the service, regular and reserve (including surviving beneficiaries) will be entitled to receive the same benefits for injury or death in the performance of their duties as civil officers and employees of the United States under the United States Employees' Compensation Act. Such commissioned officers will be entitled, in time of war, to limited military benefits with respect to all active service in the Public Health Service, to full military benefits while detailed for duty with the Army, Navy or Coast Guard or while serving outside the continental limits of the United States or in Alaska in time of war. The President is authorized, at any time during which the country is at war, by executive order to declare the commissioned corps of the Public Health Service a part of the military forces, and on the issuance of such an order commissioned officers of the service will be entitled to full military benefits with respect to active service rendered while the Public Health Service is a part of the military forces of the United States.

The new law provides further that in time of war or national emergency any commissioned officer of the regular corps of the Public Health Service may be appointed to higher temporary grade with pay and allowances thereof without vacating his permanent appointment. The surviving beneficiaries of any commissioned officer of the service who, since Dec. 7, 1941 and prior to Nov. 11, 1943, the date on which the law was signed, has lost his life while on active duty in the service or while detailed to the Army, Navy or Coast Guard, shall receive six months' pay and certain other benefits. The law declares eligible for appointment as reserve officers in the Public Health Service graduates of reputable osteopathic colleges. This authority will remain in effect for the duration of the war and for six months thereafter.

Legislation pending respectively in the Senate Committee on Education and Labor (S. 1683) and in the House Committee on Interstate and Foreign Commerce (H. R. 3379) contemplates a codification of the laws relating to the Public Health Service.

Obstetric and Pediatric Care for Wives and Infants of Servicemen.—The Seventy-Eighth Congress, to date, has appropriated the sum of $24,200,000 for use by the Children's Bureau in making allotments to the several states to provide obstetric and pediatric care for the wives and infants of servicemen. Shortly after the Seventy-Eighth Congress convened, President Roosevelt requested an appropriation of $1,200,000 to continue a program that had been in operation since August 1941 to provide these services. Prior to that time the program had been financed under allotments made by the Children's Bureau, totaling $390,177, from the regular appropriation authorized by the Social Security Act for maternal and child health activities. Following the submission of the request for additional appropriations, the House Committee on Appropriations refused to recommend the inclusion of the requested amount in a deficiency appropriation bill, principally on the ground that there was in existence no legislation authorizing the program and therefore the House of Representatives was without authority to appropriate money for its extension. Efforts were made on the floor of the House to amend the deficiency appropriation bill, but they failed. When this bill reached the Senate, however, it was amended to include the $1,200,000 requested, and the House thereafter accepted the Senate amendment.

This appropriation was soon exhausted and again an estimate was submitted to Congress by the President in the amount of $4,400,000, and this time the House Committee on Appropriations reversed its previous stand and included the amount in the regular appropriation bill for the Department of Labor, H. R. 2935, which subsequently became a law. In this bill the program was extended to include as beneficiaries the wives and infants of enlisted men of the first, second and third grades. Previously the wives and infants of enlisted men in only the fourth, fifth, sixth and seventh grades were entitled to benefits. The Congress, too, attached to this authorization for appropriation a proviso restricting the Children's Bureau from promulgating regulations relating to the care of obstetric cases which discriminates between persons licensed under state law to practice obstetrics. This proviso was incorporated in the law at the instance of osteopaths. There followed some misunderstanding of the effect of the proviso, and the Children's Bureau submitted the matter to the Attorney General of the United States for an opinion. That official advised the Children's Bureau that the proviso meant only that that bureau could not itself set up standards to be met by participating physicians, that such standards thereafter were to be established by the several states in plans submitted to the Children's Bureau for approval. The result is that a state may, if its laws permit, restrict participation in the program to practitioners who are professionally qualified to render adequate obstetric care to the wives of servicemen and the Children's Bureau may approve a plan so limiting participation.

Early in the fall of last year it became evident that additional appropriations would be necessary to finance the program, and the President submitted a third supplemental estimate to the Congress in the amount of $18,600,000 for allotments to the states. When it became known that this estimate was to be submitted to Congress, a letter was sent to each Congressman and to each Senator embodying a copy of the resolution adopted by the House of Delegates last June, urging that the method of making available these federal funds be changed so that the money could be paid to the wives of servicemen on an allotment basis. When the House joint resolution proposing an additional appropriation came before the House of Representatives, an amendment was offered to put the program on an allotment basis. After considerable discussion, however, this amendment was rejected by a vote of 115 to 8. The joint resolution was thereafter passed by the House and Senate and signed by the President. This latest appropriation measure restricts the beneficiaries to the wives and infants of servicemen in the fourth, fifth, sixth and seventh grades with a saving clause under which payments out of the appropriation could be made for commitments made prior to Oct. 1, 1943 in cases of wives and infants of enlisted men in grades one, two and three.

In opposition to providing allotments to the wives of servicemen, it was contended that in many instances the money allotted would be used by the wives to meet "immediate needs" rather than used to procure the needed obstetric and pediatric care. The same argument may also be advanced against any cash allotment now being made to the wives of servicemen. Present allotments, presumably, are made to enable the wives of servicemen to obtain the necessities of life. They may be expended for frivolous purposes, thereby defeating the purpose of the government to help the families to obtain food, clothing and shelter. It was contended, too, that the allotment program would cost at least $30,000,000 a year more than the service program. This contention was based on the assumption that 645,000 wives of enlisted men will have babies during the present fiscal year and that approximately half of the number will apply for help under the present program. The assumption was made that if the cash allotment plan was put into effect all of the 645,000 wives would be entitled to the allotment, and on the basis of this assumption it was estimated that the cost of the allotment program would exceed the service program in the indicated amount. It may be pointed out that all of the 645,000 wives who will have babies during the present fiscal year are now entitled, on request, to the benefits of the program that obtains. The wives receive the benefits, however, only if they ask for them, and about 50 per cent have so requested.

The cash allotment plan could be put on the same basis as the service plan; namely, it could be made available only to those wives who request it.

It was contended, further, that a flat grant would necessarily have to be made without regard to individual medical needs or the cost of care and that such grants would not be sufficient to cover extraordinary medical expenses. An allotment, however, could be based on individual needs and could be made to cover whatever expenses were incurred by the wife of a serviceman to procure necessary medical and hospital care. The objectors to the allotment proposal pointed out that, even though the wife of a serviceman had the necessary money to procure needed care, she might not be able to obtain it by reason of inability to obtain the services of a physician. Under the existing plan, it was contended, a duty devolved on state health agencies to aid in obtaining the services of a physician if the wife was unable to procure them. Machinery could be set up in each state, however, to help the wife of a serviceman to obtain necessary care if a cash allotment scheme was put into operation.

It was finally contended that if a flat grant was made to the wife there would be no assurance that the fees charged by the physician or hospital would be within the cash grant. In the case of other cash allotments there is no assurance that in individual cases they will be sufficient to provide the necessities of life for the families of the servicemen. Furthermore, practically all state medical associations have approved the general program of providing obstetric and pediatric care for the wives and infants of servicemen, and such state associations could and would evolve a setup to reduce to a minimum the cases in which a few physicians might undertake to overcharge. The greater proportion of physicians would patriotically accept the amount allotted to the wife of a serviceman as reimbursement for his services if such amount represented the most that the wife of a serviceman could pay.

Funds for Relocated Physicians.—The problem of relocating physicians to critical areas has been receiving serious consideration for some time. Despite all the efforts that have been made, however, there apparently still remain areas in which the urgent need for physicians has not been met. In an effort to meet this need, the President on October 1 requested an appropriation of $1,000,000 to enable the United States Public Health Service to supply the needed medical care in these areas through the use of its own personnel or by means of monthly stipends to induce private practitioners of medicine to move into them.

This federal fund, it was contemplated, was to be used by the Surgeon General of the Public Health Service when requested by a state department of health (1) to assign medical and dental personnel of the service to areas found to be in critical need, the services of such personnel to be furnished the public in accordance with schedules of fees approved by the state health departments and the Surgeon General of the Public Health Service or (2) to enter into agreements with private practitioners of medicine and dentistry under which, in consideration of the payment to them of a relocation allowance of not to exceed $250 per month for three months and the actual cost of travel and transportation of the physician or dentist and his family and household effects to the new location, such physician or dentist would agree to move to and engage in the practice of his profession in the critical area for not less than one year.

The House Committee on Appropriations initially refused to include the estimates in an appropriation bill. The committee expressed hesitation in inaugurating a program of this character with federal funds to provide direct medical attention to the civilian population with physicians paid by the federal government. The committee thought that out of the cooperative efforts of the federal government, the medical associations, the state departments of health and the communities themselves there should come a concerted and spontaneous effort to provide needed medical care in the critical areas. The committee said:

> Most of it [the need] is in war industry areas and it is inconceivable that such communities working with the industries, the affected population, and state and local authority, cannot inaugurate and maintain an adequate public spirited program, financially sound, to serve this need. If the affected areas cannot and will not solve their local needs it may be necessary for the federal government in the interest of the general public health to step in but until then the committee feels that federal funds should be withheld under the contemplated procedure.

When the First Supplemental National Defense Appropriation Bill for 1944 (H. R. 3598) reached the floor of the Senate, an amendment was offered by Senator Russell of Georgia to authorize a part of the appropriation requested by the President. This amendment was accepted by the Senate and thereafter by the House, with some modifications suggested by a conference committee. As finally enacted, the sum of $200,000 was made available to provide medical care in the critical areas, instead of the $1,000,000 initially requested. The Public Health Service may not assign its own personnel to such areas but must use the money to pay relocation allowances not to exceed $250 a month for three months plus moving expenses to private practicing physicians and dentists who will agree to relocate. The local community requesting help must assume 25 per cent of the cost of procuring it, and the law specifically provides that the relocated physician or dentist must obtain a license to practice in the state to which he moves. Procedures are now under way by the United States Public Health Service to put into operation the program authorized by this federal appropriation.

Additional Hospital Facilities for Veterans.—Proposals are pending in Congress contemplating a vastly expanded program for the construction of hospital facilities for veterans of World War II. In an appropriation bill approved Dec. 23, 1943 the Congress appropriated $10,356,000 to provide 3,950 additional beds for neuropsychiatric patients. On Jan. 29, 1944 the President transmitted to Congress a request for an additional $30,000,000 for the construction of 9,252 additional hospital beds for neuropsychiatric patients. In addition, another appropriation of $7,374,500 has been made available for major alterations and repairs and for construction not providing additional beds. Representative Rogers of Massachusetts has introduced a bill, H. R. 3935, proposing an appropriation of $500,000,000 to provide additional hospital and outpatient dispensary facilities for veterans.

The American Legion has sponsored the introduction in Congress of legislation to enact a Servicemen's Aid Act of 1944, commonly referred to as the G. I. bill. This legislation was introduced in the Senate by Senator Clark as S. 1767, for himself and seventy-eight other senators. It declares the Veterans' Administration to be an agency of the United States vital and essential to the successful prosecution of the war and entitled to priorities second only to the War and Navy Departments; directs the Administator of Veterans' Affairs and the Federal Board of Hospitalization to expedite the construction of additional hospital facilities for war veterans and to enter into agreements and contracts for the use of suitable Army and Navy hospitals by the Veterans' Administration after cessation of hostilities and after such institutions are no longer needed by the armed services; appropriates $500,000,000 for the construction of additional hospital facilities; authorizes the Administrator of Veterans' Affairs and the Secretary of War and the Secretary of the Navy to enter into agreements for the mutual use or exchange of use of hospital and domiciliary facilities; provides for the transfer or detail of commissioned or enlisted personnel from the armed forces to the Veterans' Administration and provides for the postwar education and training of any person who served in the active military or naval service on or after Sept. 16, 1940 and prior to the termination of the present war and whose education or training was interrupted or prevented by service or who requires a refresher or retraining course to fit him for employment or profession. This bill passed the Senate without a dissenting vote and is pending in the House Committee on World War Veterans' Legislation.

From 1919 through the fiscal year ended June 30, 1943 the Congress has specifically appropriated the sum of $174,688,267 for new hospital, domiciliary and outpatient dispensary facilities for veterans. In addition, since 1923 there has been expended from regular fiscal funds available to the Veterans' Administration the sum of $26,572,347 for permanent improvements and extensions to facilities. The Veterans' Administration, furthermore, has been allotted for improvements and new construction the sum of $3,041,650 from the National Recovery Act of 1933 and the sum of $13,268,200 from the Public Works Administration Appropriation Act of 1938. An additional sum of $1,133,448 was expended for improvements from the general post fund established by the former National Home for Disabled

Volunteer Soldiers. In all, a total of $218,703,912 has been made available for construction purposes during the past twenty-four years.

On June 30, 1943 the Veterans' Administration was operating hospital facilities at ninety-three locations in forty-five states and the District of Columbia, having a capacity of 61,764 beds. In addition there have been set aside 18,455 beds for domiciliary care and facilities under the jurisdiction of the Veterans' Administration. As of June 30, 1943 the total hospital load of the Veterans' Administration was 56,897, including 45,653 veterans of World War I, 5,132 veterans of World War II, and the remainder were veterans of other wars and certain miscellaneous beneficiaries.

Of the patients in hospitals at the close of the year, 8.82 per cent were under treatment for tuberculosis, 64 per cent for neuropsychiatric diseases and 27.18 per cent for general medical and surgical conditions.

Since June 7, 1924, when hospitalization was first authorized for veterans of all wars without regard to the origin of their disabilities, 1,862,965, or more than 80 per cent of all admissions, have been for the treatment of disabilities not connected with service. Over 92 per cent of the admissions for the fiscal year ended June 30, 1943 were on account of non-service connected disabilities. In this connection it is important to note that of the 5,132 veterans of World War II hospitalized during the year only 2,332 were under treatment for diseases or injuries determined to be of service origin.

The Veterans' Administration is authorized to provide hospitalization for all veterans, including veterans of World War II, for non-service connected disabilities so far as existing governmental facilities will permit. At the close of the fiscal year, on June 30, 1943, 74.98 per cent of the United States veterans under hospitalization were receiving treatment for disabilities not of service origin.

Vocational Rehabilitation for Veterans and Civilians.—In October 1942 the President sent a special message to Congress advocating an expanded federal-state program for vocational rehabilitation to cover both veterans and civilians and to be administered by a single rehabilitation service in the Federal Security Agency. Bills were introduced in the Seventy-Seventh Congress to carry out the President's recommendation, but no final action was taken on them, owing in part to the opposition of veterans to a combined veteran-civilian rehabilitation program administered by the Federal Security Agency. Shortly after the Seventy-Eighth Congress convened, Senator LaFollette of Wisconsin and Representative Barden of North Carolina sponsored legislation to enact a Vocational Rehabilitation Act Amendments of 1943. This legislation included both veterans and civilians and contemplated the creation in the Federal Security Agency of an Office of Vocational Rehabilitation as the administrative agency. Opposition to the program by the veterans continued, and in the end all reference to the rehabilitation of veterans for disabilities due to or accelerated by service was stricken from the Barden-LaFollette legislation and a separate law enacted for the veterans, leaving the administration of rehabilitation in the Veterans' Administration. Following this action the Barden-LaFollette legislation was passed.

Briefly, the law relating to the rehabilitation of veterans, Public Law No. 16, affords vocational rehabilitation through the Veterans' Administration to those veterans of World War II who served in the active military or naval service at any time after Dec. 6, 1941 and prior to the termination of the present war who (1) were honorably discharged from such service, (2) have disabilities incurred in or aggravated by such service for which pension is payable or would be payable but for the receipt of retirement pay and (3) are in need of vocational rehabilitation to overcome the handicap of such disability. No course of training may extend beyond a period of four years.

An analysis of the Barden-LaFollette Act (Public Law No. 113) was prepared by the Bureau and published in THE JOURNAL, Oct. 30, 1943. The program will be administered, from a federal level, by an Office of Vocational Rehabilitation in the Federal Security Agency. On a state level it will be administered by state boards of vocational education or by state rehabilitation commissions except in the case of rehabilitation of the blind. If under a state law the state blind commission or other agency which provides assistance to the adult blind is authorized to provide vocational rehabilitation, the state plan will be administered by such state blind commission or other state agency so far as the plan applies to vocational rehabilitation of the blind. A state plan, to be approvable by the federal agency, must provide rehabilitation to classes of employable individuals defined by the Administrator of the Federal Security Agency and to any civil employee of the United States disabled in the performance of his duty. Such rehabilitation must be provided too to war disabled civilians whose disabilities have resulted, without personal misconduct, from injury or disease or from an aggravation of a preexisting injury or disease incurred in line of duty while serving at any time after Dec. 6, 1941 and prior to the termination of the war (1) in the Aircraft Warning Service, (2) as a member of the Civil Air Patrol, (3) as a member of the United States Citizens' Defense Corps in the protective services in civilian defense, (4) as a registered trainee taking training for such protective services or (5) as an officer or member of the crew of a vessel owned or chartered by the Maritime Commission or the War Shipping Administration or operated under charter from such commission or administration.

The federal government will participate financially in the program as follows: (1) It will reimburse a state for all of the administrative expenses of the program, (2) it will reimburse a state in full for the cost of rehabilitation of war disabled individuals and (3) it will pay half the cost of the rehabilitation of other disabled persons. The new law provides for the physical restoration as well as the vocational rehabilitation of the disabled. A state plan must provide corrective surgery or therapeutic treatment necessary to correct or substantially modify a physical condition which is static and constitutes a substantial handicap to employment but is of such nature that such correction or modification should eliminate or substantially reduce the handicap within a reasonable length of time. Necessary hospitalization will be provided, in no case to exceed ninety days, in connection with the surgery or treatment. Prosthetic devices will also be furnished. A state plan must provide maximum schedules for fees for surgery, therapeutic treatment, hospitalization and medical examination and for prosthetic devices to be furnished rehabilitants. Such schedules will be subject to the approval of the Administrator of the Federal Security Agency.

The federal law does not require a state to limit rehabilitation procedures to persons financially unable to pay for their rehabilitation. A state may not impose a showing of financial need on a war disabled civilian or on a civil employee of the United States. Unless a state does impose a financial need requirement on a rehabilitant, however, with the exceptions just noted, who is furnished corrective surgery or therapeutic treatment or hospitalization, the state will be required to assume the full expense with respect to such services.

A national Rehabilitation Advisory Council has been created to advise the Office of Vocational Rehabilitation in the Federal Security Agency in connection with the expanded federal-state rehabilitation program. Regulations that have been issued provide for the creation of advisory committees on state levels.

Medical Care for Recruited and Migrant Farm Workers.—Under date of April 29, 1943 the President approved as Public Law No. 45 a bill appropriating the sum of $26,100,600 to be expended by the Administrator of Food Production and Distribution for assisting in providing an adequate supply of workers for the production and harvesting of agricultural commodities essential to the prosecution of the war. A certain part of this appropriation was earmarked for allotments to the several states for expenditure by the agricultural extension services of the land-grant colleges. The purposes for which expenditures from these allotments could be made included the providing of health and medical services for recruited farm workers and their families. The President under date of October 28 recommended an additional appropriation of $35,000,000 for this program, and a joint resolution was introduced in the House, H. J. Res. 208, which proposed an additional appropriation of $27,000,000 plus the unexpended balances remaining from the initial appropriation. When this joint resolution reached the floor of the Senate an amendment was adopted under which expenditures from the allotments to provide medical service to migratory agricultural workers and their families who, without recruitment or assis-

tance of any government agency, have entered an area served by a labor supply center and have engaged in agricultural work and to whom adequate health and medical services are not otherwise available in the area where they are working. This amendment was subsequently accepted by the House, and the joint resolution has been approved by the President as Public Law No. 229.

Construction of Community Facilities, Including Hospital and Medical Centers.—The Seventy-Seventh Congress enacted legislation, referred to generally as the Lanham act, appropriating $150,000,000 for the construction of defense public works, or community facilities, made necessary by national defense activities, including schools, waterworks, sewers, sewerage, garbage and refuse disposal facilities, public sanitary facilities, works for the treatment and purification of water, hospitals and other places for the care of the sick, recreational facilities, and streets and access roads. Subsequently an additional appropriation of $150,000,000 was made available by that Congress. In the Seventy-Eighth Congress, legislation was introduced by Representative Lanham authorizing an additional $200,000,000 for the construction of such facilities and Congressional action was completed on the legislation, which was approved by the President July 15, 1943 as Public Law No. 150.

Selective Training and Service Act Amendment.—The President approved under date of Dec. 5, 1943 an act amending the Selective Training and Service Act of 1940 (Public Law No. 197). This law, among other things, directed the President to appoint a commission of five qualified physicians, one an Army officer, one a Navy officer and three civilian physicians not employed by the federal government, to examine the physical, mental and moral qualification requirements for admission to the Army, Navy and Marine Corps and to recommend to the President any changes therein which the commission believes can be made without impairing the efficiency of the armed services. The Director of Selective Service will be required to reexamine rejectees, including those previously discharged from the armed services because of physical disability, to determine if they may qualify for service under any new standards that may be established. This law provides too that no individuals shall be called for induction, ordered to report to induction stations or be inducted because of their occupations or by occupational groups or by groups in any plant or institutions, except pursuant to a requisition by the land or naval forces for persons in needed medical professional and specialist categories.

Nurse Training Program.—At the request of the Federal Security Agency the Congress enacted legislation, commonly referred to as the Bolton act, to provide a nurse training program to be administered by the United States Public Health Service. The program will remain in effect for the duration of the war and will supply nurses for the armed forces, governmental and civilian hospitals, health agencies and war industries. Federal funds authorized by this act are used to provide tuition, stipends, maintenance, fees, distinctive insignia and uniforms to student nurses undergoing training in approved institutions. It was estimated at the time this legislation was before Congress that the program, based on a twenty-four month curriculum, would involve a federal expenditure of $59,290,000 for 1944, $62,550,000 for 1945 and $68,360,000 for 1946, or a total of $190,200,000 for the three year period. Based on a thirty month curriculum, the estimated federal expenditure varied slightly. These estimates were predicated on the assumption that there would be 101,000 nurses under training in 1944, 125,525 in 1945 and 141,000 in 1946. An initial appropriation of $45,000,000 for this program was included in the regular appropriation bill for the Federal Security Agency. An additional $7,500,000 was made available in the First Supplemental National Defense Appropriation Act, 1944. A request for an additional $2,700,000 was transmitted to the Congress on February 4 of this year and is pending in the House Committee on Appropriations.

Distinct Color for Powdered Insecticides.—Companion bills pending in the Congress, S. 897 and H. R. 2383, propose to amend the Insecticide Act so as to provide that any white powder insecticide or fungicide containing arsenic in its elemental form or in any of its combinations, or fluorine in any of its combinations, shall be deemed to be adulterated unless it is distinctly colored in accordance with regulations promulgated by the Secretary of Agriculture. The Secretary of Agriculture will be authorized to grant exemptions in particular cases if he determines it to be unnecessary that the insecticide or fungicide be colored in order to protect the public health. The Senate bill has been favorably reported by the Senate Committee on Commerce. The House bill is pending in the House Committee on Interstate and Foreign Commerce.

This legislation was recommended to the Congress by the Department of Agriculture as necessary to put a stop to the poisoning of people through the careless handling of white powdered insecticides and fungicides. In the letter transmitting the legislation to Congress, it was pointed out that in a New York hospital serious illness of 45 persons and two deaths occurred through eating food accidentally contaminated with sodium fluoride insecticide, that in Pittsburgh at a Salvation Army community center dinner 57 persons were poisoned, 12 of whom died as a result of eating food prepared from flour contaminated with an insecticide and that at a state hospital in Oregon 467 inmates were made ill, 50 of whom died, through eating food accidentally contaminated with sodium fluoride.

Study of Human Nutrition and the Nutritive Values of Food.—A bill introduced in the House of Representatives, by request, by Representative Pace of Georgia, H. R. 2276, provides for the development of better diets and an improved nutritional status for the people of the United States. The bill is pending in the House Committee on Agriculture and would authorize during the present emergency an annual appropriation of $1,000,000 for allotment to the states to pay the necessary expenses of conducting studies of the urgent problems of human nutrition and of the nutritive values of food and to provide the information needed to assure the best use of the food supply in the emergency, such studies to be conducted by the agricultural experiment stations established in the several states. Not to exceed 2 per cent of the sums appropriated will be used for administrative purposes. Ninety-eight per cent of the sum appropriated, it is contemplated, will be paid to the several states as follows: (1) the sum of $10,000 to each state and (2) the sum remaining will be paid to the several states in the proportion that the total population of each bears to the total population of all the states as determined by the last decennial census. In addition, an annual appropriation of $500,000 will be authorized for the use of the Secretary of Agriculture to make similar studies and to cooperate with the several experiment stations in such research.

Investigation of the Educational and Physical Fitness of the Civilian Population as Related to National Defense.—A Senate resolution has been agreed to, authorizing the Senate Committee on Education and Labor or a subcommittee thereof to make a full and complete study and investigation regarding the distribution and utilization of medical personnel, facilities and related health services and the deficiencies in health and education among persons otherwise fit for service with the armed forces and persons otherwise fit to be employed to the best advantage in agriculture, industry and other activities. The Senate Committee appointed a subcommittee to carry out the investigations, composed of Senator Pepper of Florida as chairman, Senator Thomas of Utah, Senator Tunnell of Delaware, Senator LaFollette of Wisconsin and Senator Wherry of Nebraska. The investigations of this subcommittee are under way.

Treatment of Selective Service Registrants Infected with Venereal Disease.—Legislation is pending, introduced by Senator LaFollette of Wisconsin as S. 1320, to provide for the treatment of Selective Service registrants infected with venereal disease. This legislation would direct the Surgeon General of the Public Health Service to provide, on the request of state and local health authorities, (1) for the hospitalization, treatment and subsistence in hospital facilities operated by the Public Health Service of persons registered under the Selective Training and Service Act who are found to be infected with venereal disease and (2) for the transportation of such persons between their homes and such facilities whenever necessary.

Employment of Alien Physicians by Bureau of Indian Affairs.—A pending bill, H. R. 2657, introduced by Representative O'Connor, Montana, and pending in the House Committee on Indian Affairs, provides that whenever the Secretary of the Interior shall find that the Bureau of Indian Affairs cannot obtain the services of a sufficient number of physicians and

dentists who are citizens of the United States adequately to perform the functions of the bureau with respect to the conservation of the health of Indians, he or his authorized representative may, with the approval of the Civil Service Commission, engage the services, by contract or otherwise, of competent physicians and dentists who are not citizens of the United States, for periods of time not to extend beyond the termination of the present war and for six months thereafter.

Permanent Medical Corps in the Veterans' Administration.—Representative Rogers of Massachusetts has introduced legislation proposing the establishment of a permanent medical corps in the Veterans' Administration to be known as the Veterans' Administration Medical Corps and which will constitute a component part of the military forces of the United States. This legislation, H. R. 2820 and H. R. 3623, is pending in the House Committee on World War Veterans' Legislation. Since its introduction the President has directed that the medical personnel of the Veteran's Administration be militarized.

Bureau of Vital Records in the United States Public Health Service.—A bill is pending in the Senate Committee on Commerce, S. 1096, to establish a Bureau of Vital Records in the United States Public Health Service. Public hearings have been concluded on the bill, which would create in the Public Health Service a Bureau of Vital Records to be under the immediate supervision of an Assistant Surgeon General. This bureau would be administered, the bill provides, for the purpose of coordinating the vital records and vital statistics offices of the states into a cooperative vital records system, including improvement of the registration procedures of the states for the purpose of guaranteeing complete and accurate registration, preservation and availability of certificates and related records of births, deaths, marriages, divorces, legal separations, annulments, changes of name, adoptions and legitimations within the United States. The Assistant Surgeon General would compile, analyze and have printed the statistics of and reports on births, deaths, marriages and divorces obtained from data from the registration records of the states for which plans have been submitted to and approved by the Surgeon General of the Public Health Service.

To assist states and their political subdivisions in establishing and maintaining vital records services, including the training of personnel for state and local vital records work, the bill authorizes the appropriation of a sum not to exceed $2,000,000 for each fiscal year beginning with the fiscal year ending June 30, 1944. This appropriation, it is contemplated, will be allotted to the states on the basis of (1) the population, (2) the special vital records problems and (3) the financial needs of the respective states. The bill would transfer the functions of the Division of Vital Statistics of the Bureau of the Census to the new Bureau to be created in the United States Public Health Service.

Investigation of Aid Available to the Physically Handicapped.—The House Committee on Labor would be authorized under a pending House resolution, H. Res. 230, (1) to conduct studies and investigations of the extent and character of aid now given by the federal, state and local governments and private agencies to the physically handicapped, (2) to study and investigate the diffusion within the United States of such aid to the physically handicapped and (3) to investigate employment opportunities for the physically handicapped and other questions in relation thereto which would aid the Congress in the formation of any necessary remedial legislation. This resolution is pending in the House Committee on Rules.

Medical Care for Recipients of Public Assistance.—A pending bill, introduced by Representative Coffee of Washington, H. R. 2947, would authorize an appropriation of $18,000,000 for the fiscal year ending June 30, 1945 and for each fiscal year thereafter a sum sufficient to carry out its purposes, for making payments to the states which have submitted and had approved by the Social Security Board state plans for furnishing medical care to the recipients of public assistance. The term "medical care" is defined to include such services, supplies and appliances for the diagnosis, cure, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body, as may be approved in regulations of the Social Security Board. Medical care, the bill provides, may be supplied either by the state agency administering or supervising the administration of the plan or by other agencies of the state or political subdivisions, in accordance with agreements authorized in regulations of the board. Such care may be provided directly by the state agency or such other agencies or indirectly through payments by such state agency or such other agencies to the person or persons furnishing such care. If a state so desires, under the provisions of the pending legislation it may provide in its plan for the supplying of medical care to the needy members of the households of recipients of public assistance.

Social Security for Employees of Religious, Charitable, Educational and Certain Other Organizations.—A new title to the Social Security Act, title II-A, would be added by H. R. 3204, to be designated "Federal Old-Age and Survivors Insurance for Employees of Religious, Charitable, Educational, and Certain Other Organizations." Title II of the act extends federal old age and survivors insurance benefits to present beneficiaries. Similar benefits would be extended by title II-A to employees of organizations now exempt. While the existing provisions of the Social Security Act impose taxes on employers and employees, the proposed title II-A contemplates that payments to be made by exempt organizations and by their employees to the trust fund to be created will be premiums, not taxes.

Optometrists and Morticians as Commissioned Officers in Army and Navy Medical Corps.—A bill authorizing the appointment of optometrists as commissioned officers in the Medical Corps of the Army and in the Medical Corps of the Navy has been introduced by Representative Peterson of Florida, H. R. 4063. It is pending in the House Committee on Military Affairs. It would authorize the President to appoint as commissioned officers optometrists who are regularly licensed to practice as such in any state or in the District of Columbia.

Another bill, introduced by Representative Peterson of Florida as H. R. 3806 and pending in the House Committee on Military Affairs, would authorize the appointment of morticians as commissioned officers in the Medical Corps of the Army and the Medical Corps of the Navy.

Postwar Educational Opportunities for Service Personnel.—Under date of October 27 the President transmitted to Congress a preliminary report of the Armed Forces Committee on Postwar Educational Opportunities for Service Personnel. The President expressed full agreement with the recommendations made by the committee that the federal government should make it financially feasible for every man and woman who has served honorably for a minimum period in the armed forces since Sept. 16, 1940 to spend a period up to one calendar year in a school, college or technical institution or in actual training in industry so that he can further his education, learn a trade or acquire the necessary knowledge and skill for farming, commerce, manufacturing or other pursuits. The committee further recommended that the federal government should make it financially possible for a limited number of ex-service men and women selected for their special aptitudes to carry on their general, technical or professional education for a further period of one, two or three years. A number of bills have been introduced to provide the recommended postwar educational opportunities for veterans. One of these, S. 1509, was favorably reported by the Senate Committee on Education and Labor on February 9. It is pending at the present time in the Senate.

Military Rank for Members of Navy and Army Nurse Corps.—An act approved July 3, 1942 provided relative rank for the superintendent, assistant superintendents, chief nurses and nurses of the Navy Nurse Corps and provided that members of the corps shall have authority in and about naval hospitals and other medical activities as regards medical and sanitary matters and all other work within the line of their duties, next after commissioned officers of the Medical Corps and Dental Corps of the Navy. An act approved Dec. 22, 1942 provided that during the present war and for six months thereafter the superintendent and all other members of the Navy Nurse Corps shall have relative rank, pay and allowances for corresponding relative ranks in the Army Nurse Corps.

Officers of the Women's Reserve of the Navy, Marine Corps and Coast Guard have actual rank. The duties of members of

the Navy Nurse Corps bring them into contact with officers of these Women's Reserves, and the distinction between relative and actual rank has proved to be a handicap to members of the Navy Nurse Corps in time of war. To remove that handicap, legislation has been introduced, H. R. 2976, which provides that during the present war and for six months thereafter the superintendent and all other members of the Navy Nurse Corps entitled under existing laws to relative rank shall have and shall be designated by the rank which corresponds to the relative rank. The enactment of this legislation was recommended by the Navy Department, and the bill has passed the House and Senate.

A similar situation exists with respect to members of the Army Nurse Corps, and comparable legislation has been introduced to grant military rank to members of that corps, H. R. 3718. This bill is pending in the House Committee on Military Affairs.

Service in the Medical Reserve Corps in Relation to Pay.—Pending legislation, H. R. 1506, proposes to amend the Pay Readjustment Act of 1942 so as to authorize service in the Medical Reserve Corps to be counted for pay purposes. The necessity for this amendment arose out of a decision by the Comptroller General that former members of the Medical Reserve Corps could not include the time they served in that corps in the computation of their pay. This bill has passed the House of Representatives.

College and University General Extension Act.—Senator Thomas of Utah has introduced a bill, S. 1670, to promote the welfare of the people by establishing a publicly supported adult education program stemming from the state universities and land-grant colleges, by setting up a college and university adult education extension program separate from but supplemental to the cooperative agricultural extension service authorized by previous acts, thus making broadly available to community groups and individuals the full educational resources and research findings of these public institutions of higher learning. This bill, if enacted, will be administered by the United States Office of Education.

For the fiscal year ending June 30, 1945 an appropriation of $8,000,000 is contemplated, for the fiscal year ending June 30, 1946 an appropriation of $12,000,000, for the fiscal year ending June 30, 1947 an appropriation of $16,000,000, for the fiscal year ending June 30, 1948 and annually thereafter an appropriation of $20,000,000. The general extension program embraced by the bill will serve individuals whose training and education may have become obsolete through economic, social and scientific change, persons desiring to know more of the problems of commerce and industry as well as problems pertaining to the education of workers, also those interested in gaining knowledge of public safety, sanitation, health, nutrition, recreation, housing, government, town planning, school facilities and social welfare services.

Industrial Health Under Jurisdiction of Labor Departments.—There is pending in the House of Representatives, with a favorable committee report, a bill introduced by Representative Norton, New Jersey, H. R. 4371, authorizing an annual appropriation of $5,000,000 to be allotted by the United States Department of Labor to state agencies administering labor laws for use by such agencies in establishing and maintaining safe and proper working conditions "and in the preparation, promulgation, and enforcement of regulations to control industrial health hazards." State plans must be developed jointly by the state agencies administering labor laws and the federal Division of Labor Standards of the Department of Labor and must be approved by the Secretary of Labor. The bill provides that in the operation of the plans the available services and facilities of public health authorities in the field of industrial hygiene shall be utilized. This bill, if enacted, would seem to confer on labor departments jurisdiction over industrial health problems and is therefore contrary in principle to the recommendations made by the House of Delegates at the Kansas City session and by the Council on Industrial Health in a resolution adopted July 8, 1939 and thereafter approved by the Board of Trustees. In this resolution the Council expressed the belief that the interests of the industrial workers will be best served by continued concentration of industrial hygiene in the federal and state health departments. The foregoing resolution was in accord with the policy adopted by the House of Delegates in 1936.

Income and Victory Taxes.—An analysis of the current tax payment act of 1943 was prepared by the Bureau and published in THE JOURNAL, August 14. This analysis indicated the requirements of the new pay-as-you-go law so that physicians were promptly informed and could more readily comply with them. The Bureau's annual statement with respect to the physician's federal income and victory tax was published in THE JOURNAL, Jan. 29, 1944. A new revenue act was passed by the Congress over the veto of the President, February 25. A statement with respect to the changes effected by the new law was published in the March 4 issue of THE JOURNAL.

The Wagner-Murray-Dingell Bill.—Companion bills are pending in the Congress to engraft on the existing social security program a system of compulsory sickness insurance involving inevitable federal control of the practice of medicine and a diluted quality of medical care. The Senate bill, S. 1161, introduced by Senator Wagner of New York and Senator Murray of Montana, is pending in the Senate Committee on Finance. The House bill, H. R. 2861, introduced by Representative Dingell of Michigan, is pending in the House Committee on Ways and Means. An analysis of this legislation was prepared by the Bureau and published in THE JOURNAL, June 26, 1943.

Under date of October 4, Secretary of the Treasury Morgenthau advocated before the House Committee on Ways and Means, in connection with hearings on the then pending tax legislation, a broadening of the social security program "to cover practically all persons in the nation, to increase employment insurance benefits, and to provide benefits for temporary disability and hospitalization." He did not specifically mention the Wagner-Murray-Dingell bill but obviously had that bill in mind when he referred to bills "already introduced in Congress."

The Eighth Annual Report of the Social Security Board, 1943, suggested extensive revisions and expansions in the social security program, stressing the belief that provisions for health and medical care have an important place in any comprehensive and adequate program of social security. It recommended the establishment of a single comprehensive system of social insurance with provision for compensating a reasonable portion of wage loss due to unemployment, sickness and disability, old age and death, and a considerable part of the expense of hospital and medical services. It recommended that matching federal funds be made available to pay medical agencies and practitioners for the cost of medical services and supplies provided for recipients of assistance. The federal reimbursement, the board indicated, might well be based on combined costs incurred within a state for medical services to recipients under all assistance programs. If arrangements are adopted for medical services to be provided through a comprehensive social insurance system, the board said, state assistance agencies could collaborate effectively with the insurance authorities by making equitable payments so that these services would be available to assist the recipient under whatever arrangements had been developed with physicians, hospitals and others to furnish services for the insured population.

President Roosevelt sent a special message to the Congress on the state of the Union, Jan. 11, 1944. In it he referred to a second bill of rights under which a new basis of security and prosperity could be established for all, regardless of station, race or creed. He emphasized the right to adequate medical care and the opportunity to achieve and enjoy good health and the right to adequate protection from the economic fears of old age, sickness, accident and unemployment. The President asked the Congress to explore the means for implementing this second bill of rights and suggested that if "no adequate program of progress is evolved, I am certain that the nation will be conscious of the fact."

Despite these official points of view, the respective Congressional committees before which the legislation is pending give no present indication of scheduling hearings at an early date.

The report on the Wagner-Murray-Dingell bill adopted by the House of Delegates of the American Bar Association, Feb.

28, 1944 and published in THE JOURNAL, March 11, deserves special mention and commendation. As stated in an editorial in the same issue of THE JOURNAL in which the report was published, the concluding paragraph of that report should be emphasized and reemphasized:

> The Constitution of the United States is designed to protect the citizens of this republic in the exercise of the rights of free men. The provisions of that instrument can be rendered impotent when our citizens, for the sake of an apparent immediate benefit, surrender to their government such direct control over their lives that government, by imposing a constant fear on them of having those benefits withheld or withdrawn, can compel from them obedience and subservience to its dictates.

Summary

Postwar Medical Licensure.—**Medical practice acts may impose hardships on recent graduates whose entry into the military or naval service prevents licensure. It is timely that such acts be reviewed.**

Morphine Substitute.—**A synthetic coal tar product has recently appeared on the markets of the United States under the trade name of Demerol. Because of its habit forming characteristics the United States Commissioner of Narcotics has recommended that steps be taken to bring it under both state and federal control.**

Lectures on Medical Jurisprudence.—**Periodic series of lectures on medical jurisprudence, such as those scheduled recently in Philadelphia and in Los Angeles, constitute important channels for the diffusion of information in this field. The development of such channels should be given thoughtful consideration by medical societies.**

Federal Legislation.—**Congressional action has been completed on legislation providing for the appointment of female physicians in the Medical Corps of the Army and Navy, creating a Pharmacy Corps in the Medical Department of the Army and reorganizing the United States Public Health Service.**

Appropriations totaling $24,200,000 have been made available for allotments to the states to provide obstetric and pediatric care for the wives and infants of servicemen. The sum of $200,000 has been appropriated for the relocation of physicians to critical areas.

Proposals are pending in Congress contemplating a vastly expanded program for the construction of additional hospital facilities for veterans of World War II. Since June 7, 1924, when hospitalization was first authorized for veterans without regard to the origin of their disabilities, more than 80 per cent of all admissions have been for treatment of disabilities not connected with service.

Laws have been enacted providing for the vocational rehabilitation of veterans, under the direction of the Veterans' Administration, and of disabled civilians, under the direction of the Office of Vocational Rehabilitation in the Federal Security Agency.

Additional funds have been made available under the Lanham act for the construction of community facilities, including hospitals and other places for the treatment of the sick.

Congress has authorized the providing of medical care for recruited and migrant farm workers.

Other pending legislation contemplates a codification of the federal laws relating to the United States Public Health Service, a study of human nutrition and nutritional values of food, the treatment of Selective Service registrants infected with venereal disease, the employment of alien physicians by the Bureau of Indian Affairs, a permanent Medical Corps in the Veterans' Administration and the creation of a Bureau of Vital Records in the Public Health Service.

At the request of the Federal Security Agency, the Congress enacted legislation to provide a nurse training program to be administered by the Public Health Service, and $52,500,000 has been appropriated to date to finance that program.

A special Senate committee has been created to investigate the education and physical fitness of the civilian population as related to national defense. A pending resolution would authorize investigations of the aid available to the physically handicapped.

The commissioning of optometrists and morticians as officers in the Army and Navy Medical Corps is proposed by pending legislation. Other bills provide for the extension of medical care to the recipients of public assistance, provide that insecticides containing arsenic or fluorine must be distinctly colored, propose a broadening of the Social Security Act to include employees of religious, charitable, scientific and certain other organizations and provide postwar educational opportunities for service personnel.

The granting of military rank for members of the Navy and Army Nurse Corps is contemplated by two pending bills. Another bill proposes to amend the Pay Readjustment Act of 1942 so as to authorize service in the Medical Reserve Corps to be counted for pay purposes. A publicly supported adult education program is contemplated by legislation that is pending.

Companion bills are awaiting committee action proposing to engraft on the existing social security program a system of compulsory sickness insurance involving inevitable federal control of the practice of medicine and a diluted quality of medical care.

A pay as you go tax law has been passed by the Congress, the effect of which will be to place a majority of the federal income tax payers on a current basis.

A pending bill would confer on labor departments jurisdiction over industrial hygiene.

Bureau of Public Relations

The Bureau of Public Relations of the American Medical Association is devoted to extending to the medical profession and to the public information regarding the work of the American Medical Association and the progress of medical science. It is not primarily an organization for propaganda, designed to "sell" the medical profession to the public or to overcome unfavorable legislation. Its services, nevertheless, induce support of the point of view of the American Medical Association and of the medical profession by keeping the public fully informed regarding medical progress and medical affairs.

During 1943, more than 5,200 individual inquiries came to the Bureau of Public Relations from newspapers, magazines, radio stations and other mediums of public information. More than 84,000 individual items based on articles that appeared in THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION and in HYGEIA were published in daily newspapers. The number is estimated on the basis of press clippings received in the headquarters office. THE AMERICAN MEDICAL ASSOCIATION NEWS, a clip-sheet, is sent to some 1,200 newspapers, press services, magazines, radio stations, industrial house organs, medical journals and bulletins.

An analysis of the inquiries directed to the headquarters office indicate that editors, reporters, feature writers, news commentators and managers of radio stations throughout the United States look to the headquarters office of the American Medical Association as a dependable source of information regarding medical matters. The information sought has included facts and advice on every phase of the multiple activities of the Association. In hundreds of instances the response from the headquarters office has been the means of correcting inaccurate information in process of publication; in many other hundreds of cases complete elimination of inaccurate information has resulted.

The Bureau of Public Relations maintains direct contact in Chicago with the headquarters of all press associations and radio chains. One or more stories concerning material published in THE JOURNAL or in HYGEIA has been placed on the wires of press associations each week in 1943.

During 1943 the Bureau of Public Relations assisted in the public relations activities of the following organizations in the

field of medicine, through conferences of its personnel with the executives of these agencies and through the preparation of material utilized by them:

The National Foundation for Infantile Paralysis, Inc.
Baruch Committee on Physical Medicine.
Division of Public Relations of the U. S. Army Medical Department.
Division of Public Relations of the U. S. Navy Medical Department.
The American Society for the Control of Cancer.
Procurement and Assignment Service for Physicians, Dentists and Veterinarians.
Medical director of the Selective Service System.
The Division of Medical Sciences of the National Research Council.
The American Red Cross.
Medical aspects of the War Production Board, Office of Price Administration, and Rural Electrification Administration.

In addition to these contacts, which have been more or less frequent during the year, innumerable special instances have arisen in which the Bureau of Public Relations has aided the war effort by disseminating material from government agencies to both the medical profession and the public.

Attention is called to a survey made by the Opinion Research Corporation of Princeton, N. J., at the request of the National Physicians Committee, in which a cross section of public opinion was ascertained relative to the medical profession. The survey indicated that the vast majority of the American people are well satisfied with the medical care they have received from a professional point of view and felt that their physicians had a personal interest in their care. More than three fourths of the people queried had heard of the American Medical Association, and about half of these people defined its purposes with reasonable accuracy. In general, those who had heard of the American Medical Association expressed approval. . The inquiry revealed that prominent mention of the American Medical Association in public education activities had a favorable influence on public thinking. Most of the people queried thought of the purposes of the Association as being to publish new medical technics, to keep the standards of medical practice high and to give endorsement to acceptable medical products. Less than one tenth of the people interviewed thought of the Association as a "union" of physicians, as a "trust" or as being otherwise primarily a self-interested body. This would seem to indicate, in general, a proper result of the public relations activities as carried on by the Bureau with relation to the attitude of the American people toward American medicine and the medical profession.

Bureau of Medical Economics

A review of the activities of the Bureau of Medical Economics for the year 1943 suggests that some of the Bureau's activities of previous years might be suitable for discussion again.

PRINCIPLES UNDERLYING PREPAID MEDICAL CARE

Medicine has advanced by almost continuous experimentation. Improvements in diagnosis and treatment, in surgery, in the use of drugs and appliances, in the administration of hospitals and in plans of payment for medical care are now, as they have been for centuries, being retested, rejected, restricted or extended according to their effect on the health of the people. There is no trace of truth in the charge that the medical profession is opposed to experimentation to determine either the value of diagnostic and therapeutic procedures or the suitability of the methods by which medical services are made available.

There should be a definite understanding of the significance of the defects in the distribution of medical care that the new proposals in the methods of payment are intended to cure. Many persons, in case of serious illness, cannot pay the full costs of the best hospital and medical care. Neither can they pay for the best food, clothing or shelter, or for the education of which they are capable and which would make them better and more productive citizens. Many of these very real problems are more economic than medical. Medical care for the indigent is a burden that should be borne by all society and not by physicians alone. No prepayment plan of arranging for medical care for the indigent by voluntary or compulsory contributions from the beneficiaries themselves is practicable, since this group has no money with which to pay premiums.

The population group that has incomes too small to meet health necessities in the way of food, clothing, fuel and shelter cannot be expected to budget or make prepayments for catastrophic illness. These "medically indigent" are always more of an economic than of a medical problem, since their medical care, regardless of the manner by which the cost is met, must, as always, be paid for directly or indirectly out of higher incomes.

CONCLUSIONS MUST BE TENTATIVE

All the elements of the problem of distributing medical care are still so constantly changing that any conclusions must be tentative, any action experimental. A complete solution of the problem of the distribution of medical facilities and services to every one is not immediately possible. Progress must come through adjustment of individual medical needs to existing knowledge and resources. Financial resources are widely dispersed and are controlled by individuals, governments, societies and institutions. Medical resources are found almost entirely within the medical profession. Unified means of utilizing these medical resources places the duty of direction in the hands of the medical profession. The various county and state medical societies, in their effort to meet the demands placed on them by this duty, have undertaken experiments that may be helpful in an attempt to find a more complete realization of the ultimate goal of good medical care for every one.

Medical societies in different parts of the United States have repeatedly assisted in the solution of some particular health problem. The part played by state and county medical societies in the organization and operation of medical service plans is of the greatest importance. From time to time throughout the period of growth of these plans over the last ten or more years, several fundamentals have been noted and discussed in the annual reports of this Bureau. In 1935 attention was called to the fact that these experiments were so diverse that even an enumeration was considered difficult. At that time there were noted some of the undesirable features that should be avoided, if possible, in developing these plans.

TEN PRINCIPLES OF 1934 STILL SOUND

It is again urged that the medical profession continue to be alert to detect and to deal with medical service plans and other medical activities promoted by irresponsible people. Only by being constantly alert for the evidences of relaxed or unsound professional standards will it be possible to maintain high standards of service. It is suggested, therefore, that the medical profession continue to urge the application of the Ten Principles adopted in 1934.

Notwithstanding all that has been done to emphasize the value of good medical care, properly organized and administered, the public has not yet been educated to recognize the value and the cost of a complete medical and surgical service, and it has been deceived as to its cost by the propaganda for compulsory sickness insurance and many lay-administered plans. Many such plans have led their clients to believe that comprehensive service is being given through existing schemes, or could be given by proposed plans, for much less than its actual cost.

The first step should be a more adequate education of the public to the real values of a complete medical service, with greater emphasis on its actual cost. That this ideal has not been overlooked, even by medical societies that have started with a limited plan, is seen from the following statement in the Report of the Special Committee to the Massachusetts House of Delegates: "Your committee urges a gradual approach to our ultimate ideal—total medical coverage by a comprehensive policy—through well defined initial steps of partial coverage."

A desirable prepayment plan for medical care is necessarily complex. It touches closely nearly all emotions, prejudices and customs in our society. It yet lacks the experience and evolution common to most social institutions. Compulsory sickness insurance systems in every country, and throughout their entire

history, have been subject to continuous changes. In spite of their anchorage to legislation and government regulation, not one as yet shows any signs of approaching equilibrium. It is not surprising that plans of such short duration as those of medical societies in the United States are still largely experimental.

Professional supervision of all the standards of medical service must be made one of the dominant features of prepayment services, as it has always been of private practice. The protection of the subscribers, the financial security of the plans and the honor of the profession demand this.

None of the activities of modern medicine deserve more serious consideration than those which are concerned with the organization and distribution of medical services. For many years the House of Delegates of the American Medical Association encouraged state and county medical societies to experiment with prepayment methods of distributing the costs of medical care, but not until the last few years has this subject been handled with the same frankness and detail of discussion that have been used in other phases of medical practice. The difficulties which accompany the maintenance of the standards of prepaid medical care are increasingly more easily reconcilable as the objectives and potentialities of this form of medicine are clarified and perfected. The system of medical service or practice of the future must be sufficiently flexible to meet a variety of demands and at the same time maintain a high quality of medical care.

In some parts of the United States, plans for prepaid medical care did not develop as well or as rapidly as it was expected they would, and therefore it has seemed advisable to postpone further efforts in that direction until the demand for this type of medical service becomes more generally and definitely apparent.

GEOGRAPHIC SCOPE OF PREPAYMENT PLANS

The necessary legislation has been secured and administrative organizations are functioning in California, Colorado, Delaware, Massachusetts, Michigan, Missouri, New Jersey, New York (three), North Carolina (two), Oregon, Pennsylvania, Texas, Utah and Washington. Some part of the program has been undertaken, but the entire program has not yet been completed, in Connecticut, Indiana, Maine, Nebraska, New Hampshire, Ohio, Oklahoma, Tennessee, West Virginia and Wisconsin.

The California Physicians' Service, which was organized in 1939 under a general nonprofit corporation law, serves the entire state of California and in November 1943 had nearly 88,000 beneficiary members. There is a Rural Health Program conducted in cooperation with the Farm Security Administration that has small units covering some nineteen counties; War Housing Projects have about 31,000 clients. The entire service is now reported to be proceeding satisfactorily.

The Colorado Medical Service, Inc., has served metropolitan Denver since May 1, 1942. As of March 1, 1943 there were 5,000 persons covered by the Colorado Medical Service as members and 2,261 persons who were applicants to the service.

Group Hospital Service, Inc., which began operations in Delaware in 1935, sponsored a plan for medical care on Jan. 25, 1943. The area served is the state of Delaware. Contracts were not offered to the public until April 1943, and enrolment is by employed groups only. There is no deductible clause, and the plan contains no income limitation. The plan, operated through the Group Hospital Service, Inc., of Delaware, is one of the few of its kind in the United States.

The Massachusetts Medical Service was organized in July 1942 to serve the geographic area covered by the commonwealth of Massachusetts. As of December 1943 the total membership was 23,000 persons enrolled in 200 groups. It is of interest that the Massachusetts Medical Service is operated in conjunction with the Massachusetts Hospital Service.

The Michigan Medical Service was organized by the Michigan State Medical Society in 1940. The first contracts became effective on March 15, 1940. By Nov. 30, 1943 some 600,455 subscribers had been enrolled. For reasons too complicated to be explained within the space of this brief note, the early operation of the plan showed a fairly large deficit, which by the early part of 1944 had been reduced by a very substantial amount. Some joint operations, similar in some respects to joint operations in Massachusetts, were put into effect between the Michigan Medical Service and the Michigan Hospital Service.

Surgical Care, Inc., was organized late in 1942 with the approval of the Jackson County, Mo., and Wyandotte County, Kan., medical societies. On Dec. 15, 1943 the organization reported 6,500 persons covered in 200 insured groups. There is no deductible clause. Surgical Care, Inc., is coordinated with the Blue Cross Hospital Service Plan.

The Medical-Surgical Plan of New Jersey, which was organized by the Medical Society of New Jersey on March 24, 1941, was accepted in New Jersey on March 26, 1941. A certificate of authority to operate the Medical Service Administration was received from the Commissioner of Banking and Insurance. No report had then been issued on the number of beneficiaries of the plan. The Farm Security Administration began with 1,223 beneficiaries. Medical-Surgical Plan of New Jersey had some 15,000 persons enrolled as of Nov. 30, 1943.

Medical and Surgical Care, Inc., was the first prepaid medical and surgical care organization to be approved and put into operation in New York under the state insurance law. This plan went into operation in April 1940. As of March 1, 1943 the enrolment was 17,000. The area served comprises fifteen counties of central and northern New York. The original experimental plans were discontinued as of May 1942, and a new type of contract has been offered and has been in operation since October 1942.

The Western New York Medical Plan, Inc., was organized in 1939 but was not licensed to operate until February 1940. Contracts were not offered to the public until March of that year. The plan is organized under Article IX-C of the New York Insurance Law and operated on an indemnity basis in accordance with an indemnity schedule which is a part of the contract. As of Dec. 1, 1943 this plan had 22,000 members.

Medical Expense Fund of New York, Inc., on about May 4, 1940 received a permit from the State Insurance Department to solicit subscribers. The plan was incorporated in October 1939 as a medical expense indemnity corporation. As of March 1, 1943 there were 2,500 subscribers reported. The number of subscribers according to the types of contracts offered is not available. This is one of the medical service organizations that still use a deductible clause in their contracts. Enrolment is in groups or individually. It is stated that the fund offers not a plan but a framework of administration principles. In 1942 this corporation met all its obligations in full, and on Jan. 1, 1944 it had some 5,000 subscribers and almost the same number of participating physicians.

Late in 1940 a plan of medical care was suggested in the Corlears Hook section of the Lower East Side of New York City. This project, which was known as the Corlears Hook Medical Association, was established late in 1940 under the sponsorship of the Medical Society of the County of New York with funds supplied by the New York Foundation. Over the period of November 1940 and May 1942 a cumulative total of 695 families representing 2,226 persons were enrolled. Reports indicate that this organization has been terminated, worth while as the experiment seems to have been.

The Medical Service Association, Inc., Durham, N. C., which is composed of fourteen counties in that state, was organized with the approval of the Durham-Orange County Medical Society and appears to comprise the same area that it did when it was organized about the middle of 1937. On Oct. 30, 1943 the association comprised some 13,031 persons.

In North Carolina there is also the Hospital Savings Association, which has a membership of some 210,000 persons. The enrolment is limited to persons who are subscribers to the hospital savings plan. Contract benefits available to the members of the Hospital Savings Association are hospitalization for thirty days, operating room, drugs, anesthesia, routine laboratory, surgery indemnity allowance up to $75, and maternity care after ten months. All benefits are available for a period of thirty days during each certificate year.

The Medical Service Association of Pennsylvania serves the state of Pennsylvania from an office at 230 State Street, Harrisburg. On Jan. 1, 1944 there were some 8,500 subscribers. The acquisition of subscribers in the present enrolment area, western Pennsylvania, is being conducted through the enrolment facilities of the Hospital Service Association of Pittsburgh on a cooperative basis, but the Medical Service Association maintains its own identity.

In 1941 an effort was made by the State Medical Association of Texas to secure an enabling act to authorize the formation of a state prepayment plan. The state did not enact the law, but now there seems to be some doubt as to its necessity. The Dallas County Medical Plan was the first medical society plan to be organized in Texas. It was initiated experimentally on April 1, 1940. As of Dec. 1, 1943 there were some 378 subscribers, all in Dallas County, Texas. The physicians are paid according to a fee schedule. The Dallas County Medical Plan has worked closely with the Group Hospital Service, Inc. The Farm Security Administration programs were conducted in 1943 in 122 counties in Texas and served 33,793 persons. Experimental medical programs are being conducted in Cass and Wheeler counties.

Utah Medical and Hospital Benefit Association. Owing to apparent inability to secure sufficient volume, it has been deemed best to urge the hospitals to organize a Blue Cross plan for the purpose of handling hospitalization on a service basis. This is now in process.

FARM SECURITY ADMINISTRATION PLANS

The Farm Security Administration has expanded until it now has borrowers among the medical care groups in all but nine states and the District of Columbia. The type of service for which money is furnished to borrower families differs considerably throughout the area over which the plans operate, and the regions are also divided into those which operate on a fee for service basis and those that have some other method of payment.

According to the latest available information the Regions and Units of the Farm Security Administration in which some arrangements have been made to provide medical care groups with some type of medical care are as follows:

Region I, 23 units in 73 counties: Maine, Maryland, New Hampshire, New Jersey, New York, Pennsylvania and Vermont.
Region II, 3 units in 3 counties: Minnesota.
Region III, 8 units in 92 counties: Illinois, Indiana, Missouri and Ohio.
Region IV, 122 units in 150 counties: Kentucky, North Carolina, Tennessee, Virginia and West Virginia.
Region V, 166 units in 179 counties: Alabama, Florida, Georgia and South Carolina.
Region VI, 145 units in 146 counties: Arkansas, Louisiana and Mississippi.
Region VII, 28 units in 81 counties: Kansas, Nebraska and South Dakota.
Region VIII, 98 units in 106 counties: Oklahoma and Texas.
Region IX, 15 units in 24 counties: Arizona, California and Utah.
Region X, 32 units in 66 counties: Colorado, Montana and Wyoming.
Region XI, 19 units in 37 counties: Idaho, Oregon and Washington.
Region XII, 30 units in 51 counties: New Mexico and Texas.
Region XIII, 1 unit in 1 county: Puerto Rico.

STUDY OF DEATHS OF PHYSICIANS

The deaths of physicians have continued at almost the same rate annually for many years. The number varies from a high of slightly more than 3,700 in 1939 to nearly 2,900 in 1931.

Last year a study was begun to determine the facts concerning the causes and rates of deaths among physicians in order that there may be shown a better comparison of the death rates in the general population with those in the medical profession. The Association will benefit in this study by the skill and experience of a well known statistician, Dr. Louis I. Dublin.

Since this seems to be the first study of the kind for the determination of mortality rates for a professional group, much interest should develop in the results of the work, and, since all the figures from this work will represent an original contribution as to both methods and rates, there should be considerable satisfaction in developing a process that should be of value to professional groups.

It is impossible to state at present the exact time when these data will be available. However, as soon as the work is completed an announcement of the details of publication and distribution of the data will be made.

WARTIME VITAL STATISTICS

It was to be expected that, as the war effort grew in size and scope, more and more of the ordinary civil processes would be affected. Among the important civil activities thus affected is the work of the vast number of persons who have been trained in the prompt and accurate recording, reporting and analysis of data pertaining to the vital processes of the nation known as vital statistics. At present it is difficult and in many instances impossible to continue the routine processes which during normal times would have been continued automatically. The wartime demands made on available manpower have made it necessary to curtail greatly or to discontinue altogether some of the previous activities in the field of statistics.

It is hoped that this curtailment will be only temporary, but, until the military victory is complete, statistics, however vital, can be postponed for other more urgent affairs. The war must be won, otherwise there will be no need for vital statistics.

THE WAR—AND AFTER

The war emergency has been so great that the medical profession has been forced to accept compromises in governmental control of education and placement of physicians remaining at home. This same emergency has compelled the armed forces to take into the medical services young men who have had barely enough time to complete the essentials of their medical education.

These young men have been subjected to regimentation imposed by the very nature of war. When they come home to enter practice, some of them may prefer to be subject to direction. To others nothing short of total freedom of enterprise will be satisfactory. Some of the straightening out postwar work is going to demand the patience of Job and the wisdom of serpents on the part of the older and more experienced members of the medical profession. The same war emergency that has brought about such pronounced governmental control of medical education and medical practice and has reduced to an almost dangerous degree the number of physicians for the civilian population has created a large group of physicians who will enter private practice with only such experience as has come to them in combat service or in military camps and hospitals. The same emergency has produced various types of medical service plans in industrial plants. Some of these may be well conceived and well operated, but there is danger that many persons, grown accustomed in times of high wages to available low cost care, will demand continuation of the low cost feature without regard to quality of service. Such demand may result in the development of commercially controlled schemes directed by incompetent or, perhaps, irresponsible individuals or groups.

That there should be some adjustment now and in the postwar days in the nature of a better understanding between the old order and what may come to be an entirely new order there seems little doubt. But there must be no compromise between the ideal of high quality of medical care for the American people and postwar pressures. It will take courage, devotion, self sacrifice and even a willingness to face condemnation to stand against the weight of such pressure. To many the struggle may seem so great that it will be easier to follow the line of least resistance. American medicine has not grown by going with the stream. It has grown by resisting every encroachment that would rob it of its freedom to develop toward its goal of individual advancement and ever higher standards of service.

The Bureau of Medical Economics has pioneered in a small way in some phases of growth of the profession. The very war emergency that has brought the dangers pointed out has interrupted the general routine of the Bureau. With the return of peace the Bureau hopes again fully to resume its place in the work of and for the American medical profession.

Summary

As it has done each year since 1934, when the Ten Principles were first adopted by the House of Delegates of the American Medical Association, the Bureau of Medical Economics in 1943 continued to stress the soundness of these principles and to urge the medical profession to continue to be alert to deal with medical service plans promoted by irresponsible people.

A desirable prepayment plan for medical care is necessarily complex. Compulsory sickness insurance systems in every country have been subject to continuous changes, and none have yet shown any signs of approaching equilibrium. Professional supervision of all the standards of medical service must be a dominant feature of prepayment services, as it has always been of private practice.

Necessary legislation has been secured and administrative organizations for the operation of prepayment plans are functioning in fourteen states, and some part of such programs has been undertaken in ten states.

The Farm Security Administration has continued to expand until it now has borrowers among the medical care groups in all but nine states and the District of Columbia.

A study to determine the causes and rates of deaths among physicians in order to show a comparison with death rates in the general population with those of the medical profession was begun last year. Since this seems to be the first study for the determination of mortality rates for a professional group, much interest should develop in the results of the work, which will be published as soon as the study is completed.

The war emergency that has brought definite governmental control of medical education and medical practice and has reduced to an almost dangerous degree the number of physicians serving the civilian population has created a large group of physicians who will enter private practice with only such experience as could be obtained in combat service or in military camps and hospitals and has also produced various types of medical service plans in industrial plants. There is danger that many persons, grown accustomed to low cost medical care, will demand continuation of the low cost feature without regard to quality of service, which may result in the development of commercially controlled schemes directed by incompetent or irresponsible individuals or groups.

The Bureau of Medical Economics has pioneered in some phases of the growth of the medical profession. The war emergency has interrupted the general routine of the Bureau, but it is hoped that with the return of peace the Bureau will again be able to resume its place in the work of and for the American medical profession.

Bureau of Exhibits

During the year 1943 the activities of the Bureau of Exhibits were altered in character because of the war but in no way decreased in volume. The staff of the Bureau was hard pressed to keep up with the requests which were made on it. Participation in programs of graduate medical instruction and in health education was carried on in forty-three states and the District of Columbia—in all but Maine, Oklahoma, South Dakota, Utah and Vermont. Special consideration was given to requests from the Army and the Navy.

Requests for assistance outside the limits of continental United States could not be complied with because of the war. Numerous visitors from Canada, Mexico and South American countries were supplied with information, however, concerning the various activities of the Bureau.

THE SCIENTIFIC EXHIBIT

The Scientific Exhibit in 1943 was canceled along with the other scientific activities of the annual session.

The Committee on Scientific Exhibit of the Board of Trustees initiated the program for the 1944 session in September 1943 with the appointment of three special exhibit committees, while organization of the group of representatives to the Scientific Exhibit from each section of the Scientific Assembly was completed. Much of the success of the Scientific Exhibit depends on the contributions of the special exhibit committees and the section representatives. Most of their work must be done during the fall months preceding the annual session.

The Advisory Committee was reduced during the year from seven to six members by the death of Dr. D. Chester Brown. For more than a score of years he was actively interested in the affairs of the Scientific Exhibit. During his long tenure as a Trustee, he served on the Committee on Scientific Exhibit, much of the time as chairman, and it was due to his energy that the Scientific Exhibit reached its high level of excellence. In 1934, when his term as Trustee expired, he was appointed to the Advisory Committee, where he continued to exert an active influence until failing health prevented his attendance at meetings.

ASSOCIATION EXHIBITS

The Association Exhibits, which originally depicted the activities of the various councils and bureaus of the American Medical Association, have been expanded to cover many fields of scientific medicine. The total number of exhibits available for loan at the end of the year was fifty-five, of which twenty-nine were suitable for medical and other scientific groups, and the rest for public expositions and fairs. Several of the older exhibits were discontinued and seven new ones added; others were checked and brought up to date. New material is planned for the coming year to replace exhibits that have been worn out in service.

Graduate medical instruction was carried on with exhibits at thirty-five medical meetings and other scientific gatherings. State medical societies availed themselves of the opportunity to use the exhibits of the American Medical Association at annual meetings to a larger degree than ever before. The Director of the Bureau attended many of these meetings, while other members of the headquarters staff were present at some meetings. At a few meetings no representative of the Association was present, the exhibits being cared for locally. Such activities are more time consuming than is ordinarily realized, for the exhibitor must be in attendance the day before the meeting begins and stay until it is finished. With the necessary travel, a full week is often necessary for a single meeting. Two or more subjects were requested at many of the medical meetings, resulting in eighty-five medical exhibits sent out during the year, which is more than double the number sent out during 1942.

Health education was promoted with seventy-six exhibits on sixty different occasions. This was a large increase over the previous year in spite of the fact that many of the state fairs and other large expositions in which the Association is often called on to participate were canceled. The type of health exhibit which has been developed for loan purposes is suited primarily for the exposition or fair, where some thousands of people may congregate. It does not lend itself to school room purposes and afternoon meetings of small groups. Thus the numerous requests from those organizations were of necessity rejected.

MUSEUMS

Permanent health exhibits of the American Medical Association have been maintained at the Chicago Museum of Science and Industry, the Cleveland Health Museum, the Newark Museum and the Toledo Museum of Science. At the first three museums the exhibits have been supplemented with information files about health, with copies of HYGEIA on display and with question boxes. The questions are sent to the Association headquarters once a week and are answered by mail through the Bureau of Health Education. Many hundreds of persons avail themselves of this service.

Temporary health exhibits have been lent during the year to the Cayuga Museum of History and Art at Auburn, N. Y., and to the Tower of Health at Madison, Wis.

The American Museum of Health in New York is still without permanent quarters, but the exhibits of the American Medical Association which are in its possession were lent to other groups during the year.

MOTION PICTURES

The motion picture library is in need of new films to keep pace with the demand and of additional copies of the films on hand. There are only twenty-five titles in the collection, three of which were added during the year. The pictures were shown four hundred and sixty-four times at two hundred and seventy-one meetings. Transportation this year has been a serious problem; more time has been required to insure delivery of the films, thus reducing the number of showings. The secretary of the Bureau has full charge of bookings, and it is due to her efficiency that the small number of films has been shown so many times. At best only a portion of the requests can be complied with, and reservations are made many weeks in advance.

A lively interchange of information has occurred during the year with other groups interested in motion pictures, and the files of the Bureau have been open to persons who wished to check their own lists. Hundreds of requests have been answered from these files about the availability of films distributed by other organizations.

The film library of the Association contains six pictures on anesthesia, seven on physical therapy, two on syphilis and the rest on miscellaneous subjects. Seven of the films are suitable for public showings.

ARMY AND NAVY COOPERATION

Special consideration is given to requests from medical officers in the service of the armed forces. Assistance has been given to Army and Navy posts in twenty states, mostly in the form of medical motion pictures for instruction purposes. Some attempts have been made by Army officers to obtain exhibits and similar material for the instruction of enlisted personnel, but this has been difficult because of the expense, the transfer of the officer in charge and other reasons. It has been possible, however, to send a few health exhibits to Army camps.

PUBLICATIONS

During the year the fifth edition of the Primer on Fractures, prepared by the Special Exhibit Committee on Fractures, was published. The demand is still heavy for this valuable little book.

Fundamentals of Anesthesia, prepared by the Special Exhibit Committee on Anesthesia, was reprinted and the supply exhausted; new material has been added for the second edition, which was in press at the end of the year.

Two pamphlets, prepared in connection with exhibits at annual sessions, are still popular—Varicose Veins and Food Charts. Many copies have been distributed.

Summary

The Scientific Exhibit was canceled in 1943 along with other scientific activities of the annual session. A good start was made on the Scientific Exhibit for the 1944 session.

Other activities of the Bureau were doubled, with participation in graduate medical instruction and health education in forty-three states and the District of Columbia. Eighty-five exhibit units were presented at thirty-five medical meetings and other scientific gatherings. State medical societies availed themselves of this service in greater numbers than ever. Seventy-six health exhibits were sent out to sixty fairs and expositions. Cooperation was maintained with seven museums, at four of which permanent exhibits from the Association have been established.

Motion pictures continued in greater demand than ever. There are twenty-five titles in the motion picture library, which were sent out four hundred and sixty-four times to two hundred and seventy-one meetings. Special consideration was given to requests from the Army and Navy, with assistance given to posts in twenty states.

The publications prepared in connection with the work of the Bureau continued in good demand. The fifth edition of the Primer on Fractures was published, while the second edition of Fundamentals of Anesthesia was in press at the end of the year.

The Bureau of Investigation

Dr. Paul C. Barton, Director of the Bureau of Investigation, was engaged in the service of the Procurement and Assignment Service throughout the year covered by this report. Meantime the Bureau continued its part in the educational activities of the American Medical Association. The Bureau collects and dispenses information concerning "patent medicines," quacks, frauds, fakes, fads and faddists to physicians, laymen, government agencies, federal, state and municipal authorities, Better Business Bureaus, business corporations, newspapers and magazines, radio stations, civic and welfare organizations, educators and students.

INQUIRIES

Inquiries from these sources continued actively during 1943. The fact that potent ingredients of nostrums must now be declared on the labels, under the provisions of the Food, Drug and Cosmetic Act of 1938, necessarily has reduced somewhat such letters about these products as would come from persons or organizations interested more in contents or formulas than in their effects on the user, but grammar school, high school and college students continue in large numbers to inquire about the composition of "patent medicines" and their potential harmfulness. This is partly the result of contemporary interest in, and study of, consumer problems.

Questions about quackery and nostrums have also come increasingly from members of Red Cross home-nursing classes. Inquiries continue to come from physicians in the armed services, even including some who are overseas, as well as from the enlisted men under their care.

Newspapers and magazines having medical advertisements offered them have continued to inquire as to the standing of these subjects, and the Better Business Bureaus have continually called for assistance in their investigations of medical schemes, as have also the various federal agencies.

Many inquiries, and particularly those from students, dealt with more than one item, and some of them included long lists, as indicated by the fact that 3,000 inquiries represented 4,500 subjects. Approximately 33 per cent of all inquiries pertained to the same products. One item, which was in fifteenth place on the list in 1942, was in third place in 1943. Another, about which there were no inquiries in 1942, was in fifth place.

THE JOURNAL

During 1943 the Bureau contributed a total of twenty-eight articles to THE JOURNAL. These included sixteen presentations of abstracts of one hundred and seventy-one Notices of Judgment issued by the Food and Drug Administration, one abstract of nine Cease and Desist Orders and four abstracts of forty-three stipulations under the Federal Trade Commission; also there were six articles containing abstracts of twenty-one fraud orders issued by the United States Post Office Department.

PUBLICATIONS

During the year five hundred pamphlets issued by the Bureau were distributed, in addition to one hundred and one copies of the book Nostrums and Quackery and Pseudo-Medicine.

OTHER SERVICES

Physicians and educators used the Bureau's lantern slides and film strip on the nostrum evil and quackery in eight instances during the year. These cases included two presentations under the supervision of the American Red Cross.

Considerable discussion time, data and other assistances were given by the Bureau in 1943 to the Post Office Department, the Federal Bureau of Investigation, the Food and Drug Administration and the Federal Trade Commission. Some of the results of this cooperation are evident in the abstracts which the Bureau prepared for THE JOURNAL of actions taken by these agencies against various forms of quackery.

Summary

During the past year the Bureau has continued its efforts to maintain the work which was instituted in 1906 by supplying information obtained from all possible sources in regard to subjects which come within its province, to the profession and the public, by correspondence and other means.

The Bureau has contributed frequently to the pages of The Journal and has circulated its publications and lantern slides and film strip in many directions.

The Bureau's cooperation with leading government agencies which take action against medical fads and frauds has been maintained.

Committee on Wartime Graduate Medical Meetings

The central Committee of the Wartime Graduate Medical Meetings respectfully submits the following report:

This nationwide movement in graduate medical education was initiated by the American Medical Association, the American College of Physicians and the American College of Surgeons, and is authorized by the Surgeons General of the U. S. Army, the U. S. Navy and the U. S. Public Health Service. The central Committee on Wartime Graduate Medical Meetings is composed of Dr. Edward L. Bortz of Philadelphia, chairman, representing the American Medical Association; Dr. William B. Breed of Boston representing the American College of Physicians, and Dr. Alfred Blalock of Baltimore representing the American College of Surgeons. The teaching personnel and facilities of American medicine have been mobilized for the purpose of offering advanced instruction to the medical officers of the armed forces and to civilian doctors.

For working purposes the country is divided into twenty-four regions, each region with a committee of three physicians representing the three sponsoring organizations. On request from the commanding officer of a service hospital, the regional committee plans courses of instruction in the form of teaching ward rounds, clinicopathologic conferences, practical demonstrations, study groups, moving pictures and formal lectures.

Well known authorities have been appointed as national consultants for thirty-one different specialties, and each consultant has organized a national faculty for his particular field. Thus far these faculties include 1,650 teachers who are available for participation in these programs throughout the nation.

The Wartime Graduate Medical Meetings have the unqualified support of the deans and faculties of fifty-two of the nation's leading medical schools.

The statistics available in the central office up to this date are as follows:

Number of individual meetings, 77 (these are separately planned meetings ranging from a short lecture and discussion period to a six day course with a number of authorities in various specialties participating).

Number of continuation courses, 84 (these are courses of instruction in the various specialties which are scheduled to take place at the same installation at regular intervals).

Total number of Wartime Graduate Medical Meetings, 161.

Total number of daily sessions, 637.

Number of installations where meetings have taken place: Army, 107; Navy, 20; civilian hospitals, 13.

Number of states in which meetings have taken place, 40.

Lectures in Canada, 3 (at present there is another meeting scheduled for Canada at which the Wartime Graduate Medical Meetings will participate).

Approximate number of physicians who have attended these meetings, 15,000.

Number of physicians now serving on the national faculties, 1,650.

Circulation of Monthly Bulletin, 2,200.

Respectfully submitted.

EDWARD L. BORTZ, Chairman.

Commttee to Study Air Conditioning

The Committee to Study Air Conditioning, in spite of difficulties created by the war, has attempted to carry on its work, has conducted some studies and has produced a limited number of papers for publication.

Military requirements for the use of dichlorodifluoromethane, long used as an essentially nontoxic coolant in air conditioning and refrigeration, led to an increased use of methyl chloride, a refrigerant of known dangerous properties. The reason for the substitution of methyl chloride is that the mechanical devices formerly used for the Freon gases (dichlorodifluoromethane) are such that no other refrigerant than methyl chloride might be used without extensive and probably impossible mechanical alteration. Knowing past disastrous experiences with methyl chloride, this committee investigated the situation and in THE JOURNAL published an appraisal of the matter, warning against the dangers involved in any improper use of methyl chloride. Although this report may have been of some value, there are newspaper reports of some fatalities and more nonfatal accidents following inhalation of methyl chloride vapors from leaks in cooling systems.

This committee long has accepted air conditioning as one preventive measure in connection with noise abatement. In this account an investigation was carried out which led to publication in THE JOURNAL, Oct. 23, 1943, of an article entitled "The Abatement of Noise." In this investigation the committee was aided by Mr. John D. Goodell of the Signal Corps of the United States Army.

Without sharing the actual work of one of its committee members, the committee has sponsored one publication by Dr. Alvan L. Barach dealing with a new method of tuberculosis therapy based on the principle of modified air pressures leading to the complete nonbreathing of the patients for prolonged, predetermined periods. This report is entirely the work of one committee member and not of the committee.

In the belief that medical students as trained in most medical colleges are inadequately instructed in the essentials of air conditioning and with particular reference to health, this committee in cooperation with the Association of American Medical Colleges is in process of compiling adequate instruction material which will be placed at the disposal of all medical colleges for whatever use these several colleges may elect.

At one of its meetings the committee reviewed the matter of the use of aerosols for the purposes of air sanitation. Without condemning this growing practice, the committee, up to the present time, does not accept as valid all of the claims that have been made in promoting the values of aerosols. The position of the committee is that aerosols have limited values but not extraordinary values.

In its meetings and in its correspondence the members of the committee have maintained a continuous appraisal of developments in air conditioning in relation to health, but many of these items of discussion do not warrant mention in an annual report. As in the past, the committee will continue to prepare and promulgate brief reports for the medical profession in relation to the air conditioning situation such as may appear to be helpful.

Respectfully submitted.

CAREY P. MCCORD, Chairman.
ALVAN L. BARACH.
WALTER M. SIMPSON.
C. P. YAGLOU.

Committee to Study Problems of Motor Vehicle Accidents

There is always the danger in such historic days as these that many of our immediate problems are more or less placed in eclipse by spectacular events in the various theaters of war and on the domestic scene. We run the risk of losing a proper perspective of the whole. We are inclined to underestimate the consequence and usefulness of our own appointed tasks in the whole machinery of our social, industrial and economic life. Traffic problems, for example, pale before the horrible death march of Bataan, the artillery and aerial bombardment of Cassino and the maneuvers of a crucial political campaign. Yet, viewed in its proper relation to the whole sweep of current events, the actual job of conserving human life and precious vehicles and of lowering economic costs has never been of more vital importance. We cannot today countenance for one moment a relaxation of combined or single efforts to reduce traffic accidents.

In 1943 traffic fatalities totaled 23,300, which represents a decline of 18 per cent compared with the previous year and 42 per cent with the 1941 figure of 39,969. Actually, the reduc-

tion in deaths was due primarily to the reduction in miles of travel. The death rate on a mileage basis was really greater in 1943 than in 1942. Furthermore, September of 1943 marked the beginning of an upward trend which has continued. Surely this gives cause for careful reflection.

POSTWAR PROBLEMS

It is reasonable to presume that when wartime bans are lifted and vehicles deteriorated by age again swarm the highways and drivers, either rusty from lack of driving or trained to army standards of operation, once more are extended prewar driving privileges, we may expect what has already been termed the "worst traffic headache" the nation has ever experienced. Estimates by conservative elements set the 1950 traffic death toll at 50,000.

There is little reason to believe that during the postwar period the public will tolerate a high accident toll. Surely we shall not be able to afford it either socially or economically. Because leading accident prevention agencies are cognizant of these facts, plans are now under way to prepare for known problems and to anticipate as far as possible the unknown.

Our street and highway system has long been labeled inadequate by informed engineers. A vast network of highways calls for construction or reconstruction. A forward step in this direction has already been taken with the recent debut of the report of the National Interregional Highway Committee. This report has been termed by Mr. Sidney J. Williams, general manager of the National Safety Council, as "the greatest single contribution ever made to highway safety." Mr. Williams says "The MacDonald standards are based on safe travel at speeds of 50 to 75 miles an hour depending on terrain. I hope this will once for all lay the ghost of 'hundred mile an hour highways.' We can build—at a price—hundred mile an hour highways and hundred mile an hour cars, but where are we going to find hundred mile an hour drivers?" This committee feels sure that fellow members of this Association will agree with this statement. Yet we must expect higher speeds with the war's end. When present limits are lifted, speeds will probably rise sharply. Already the average speeds on rural highways are increasing. And here once again the finger of guilt is leveled at the driver. Here is the controlling factor—the limiting factor.

In a notable article published some years ago Dr. Stookey, the author, stated: "The most difficult problem in the campaign for safety is neither the road nor the car. It is the human element. Roads can be rebuilt; new principles of car design can be adopted, but the driver's nervous system cannot be made over. . . . His reactions within certain limits are fixed. Yet, he too must be controlled."

Motorist limitations, speeds and highways are not the only problems which loom on the postwar horizon. The condition of vehicles, for example, is expected to be a serious one. It seems to be conceded generally by the automotive industry that new cars will not roll off assembly lines with the signing of the peace. It will take time for the industry to reconvert. With the current stockpile of replacement parts already dangerously low and with many tires worn perilously thin, it seems reasonable to assume that the condition of the vast majority of cars will pose a definite safety problem.

Then too the removal of the "conservation incentive" may tend to produce outbursts of careless and even reckless driving. The greater number of motorists have complied with gasoline and tire rationing because of the patriotic appeals for conservation. Discard these appeals and you have a natural urge to drive "prewar style"—a style which claimed almost 40,000 deaths in a single year (1941).

Drinking and driving unfailingly constitute a problem. But it is not presumptive to predict that the present scarcity of liquor may result in a current shrinkage of the actual number of these cases. During 1942 the proportion of drivers and pedestrians reported to have been drinking increased over the previous year. A driver or pedestrian who had been drinking was reported involved in one out of every five accidents. Summaries showed that 11 per cent of the drivers involved in fatal accidents had been drinking; and one out of every six adult pedestrians. Figures for 1943 are not at present available.

The committee has included within its report this very brief mention of present and anticipated postwar traffic problems in the hope of acquainting members of this Association with the current thinking of organizations in the field of traffic safety. It is now pertinent that we append their thoughts with regard to the medical man's part in this particular social and economic problem.

"There is at present—and more so than at any other time in the history of traffic safety—a great need for the viewpoint and advice of the medical man. If we are to preserve, for example, the gains we have made in the field of driver licensing; to supplement and increase as we go along and at the same time refrain from imposing restrictions of a harsh and unfair nature upon the physically and emotionally impaired men returned from service, it is imperative that we work closely with and lean heavily upon the medical profession in cases of this nature" (Dr. Donald S. Berry, director, Traffic and Transportation Division, National Safety Council).

THE PHYSICIAN AND DRIVER LICENSING

There are standards for the examination of motor vehicle operators which produce satisfactory results, but only if effectively administered by trained and capable personnel. These standards give consideration to physical defects such as impaired limbs, poor vision and deafness and offer methods of limited operation based on conditions. In the past years, however, administration of driver examinations in the majority of the states has been on a hit or miss basis, and only in isolated instances were physicians consulted regarding an applicant's physical or mental condition.

Today the need for medical consultation and cooperation is almost essential. The physically unfit, the psychoneurotics released from the service, have been given a top place in most postwar programs. Actually they represent a problem already with us. Large numbers of these men are returning monthly to resume their places in the society they left to fight for and preserve. As medical men we know that the prolonged strain of nerves imposed by war will bring certain repercussions to even those released as "fit." But the actual cases of the physically maimed and the emotionally unstable—what of these? Can we not expect to face new problems and difficult ones, particularly in such fields as driver examination?

The medical man's interest in this problem may take two paths: (1) the normal interest of a normal citizen in good government and (2) cooperative action. Point 2 would embrace the following.

(*a*) Cooperate with motor vehicle authorities and examiners.

(*b*) Lend assistance in initiating driver licensing standards in states where heretofore none have existed or authorities have failed to administer them properly.

(*c*) Lend support to maintaining standards already established in those few states where thorough examinations are given.

(*d*) Warn patients whom you consider physically or mentally unfit to drive a car of the danger to themselves and to others because of their driving.

(*e*) Make every effort to execute promptly those forms which your patients bring to you at the request of motor vehicle authorities.

There exists the very great danger that public sentiment toward licensing activities may be influenced by a strong sense of sympathy toward those who have become physically or mentally impaired through no fault of their own. Public opinion in this direction could most certainly establish a trend toward lowered licensing standards, which in turn could result in a great increase in traffic deaths.

There is no disagreement concerning the considerations which should be extended to returning service men, particularly those who have suffered serious physical or mental injuries. But to allow the latter group to operate automobiles as they did in the past, and some may even drive busses or taxicabs, is endangering not only their lives but the lives of others every time they get behind the wheel.

Because of these anticipated "human failures," mental or physical, known or unsuspected, the medical profession has here not only an opportunity but a real call to perform a very genuine service in the interests of safer driving and the ultimate saving of lives. It is a call which should not go unheeded.

THE PHYSICIAN AND CHEMICAL TESTS FOR INTOXICATION

As stated in previous reports of this committee, the physician can aid enforcement officers in the control of drinking drivers by examining such drivers suspected of being under the influence and seeing that these cases are prosecuted in a scientific manner rather than relying on hit or miss lay opinion. The committee again renews its recommendation that any physician who is called on to testify in such cases fully acquaint himself with the work done by the National Safety Council in this regard, and that he secure from the council copies of reports describing standard procedures for making examinations and for avoiding legal pitfalls in taking specimens, making the chemical analyses and presenting testimony in court.

The committee, of course, reiterates its previous statement that the percentage of alcohol in the blood is a reliable index of the degree of intoxication, especially when considered along with external symptoms of intoxication. There is listed in brief form the chemical standards for the legal interpretation of "under the influence of alcohol" in terms of the percentage of alcohol in the blood or its equivalent in other body materials:

1. Below 0.05 per cent alcohol in the blood: no influence by alcohol within the meaning of the law;

2. Between 0.05 and 0.15 per cent, a liberal, wide zone: alcoholic influence usually is present, but courts of law are advised to consider the behavior of the individual and circumstances leading to the arrest in making their decision;

3. 0.15 per cent: definite evidence of "under the influence," since every individual with this concentration would have lost to a measurable extent some of that clearness of intellect and control of himself that he would normally possess.

These standards have proved themselves to be fair and practical. The zone below 0.05 per cent vindicates the non-drinking or temperate driver, the wide middle zone considers tolerance and idiosyncrasy, and the highest zone indicates alcoholic influence regardless of unusual tolerance. The chemical tests can be performed with remarkable accuracy and are the best means of proving alcoholic influence. It is necessary, however, that care be used in making the tests and that those who run the analyses have sufficient experience and are able to show that they can perform the tests accurately.

Since the last report of this committee, it is interesting to note that many cities have adopted chemical tests for intoxication.

THE PHYSICIAN AND FIRST AID

The committee renews the recommendations made in previous reports that every physician carry in his car at all times a first aid kit so equipped that he may handle efficiently the immediate treatment which may be needed in traffic accidents.

THE PHYSICIAN AND HIS DRIVING

Owing to the increasingly heavy burdens placed on members of the medical profession in the past two years, it is only wise to mention again the driving habits of the physician himself. Fatigue contributes heavily to traffic accidents. Because of the great inroads the armed services have made into the medical profession, the practices of most physicians today have doubled and tripled. Fatigue under these circumstances is inescapable. The medical man should, however, make compensation for this fact in his driving. Every rule of caution should be observed.

There is always the criticism that physicians sometimes take advantage of their driving privileges, and it is a privilege as distinguished from a right. Let it suffice to say that it is a privilege which should never be abused.

THE PHYSICIAN AND HIS ADVICE TO PATIENTS

It has often been suggested by traffic safety authorities and others that when a physician in the course of his practice treats a patient whom he knows to be unfit physically to drive a car, he should warn the patient of the danger to himself and to others because of his driving. This does not represent an unreasonable request.

As physicians we know or should know from our training that certain persons with permanent or temporary deficiencies should not drive a car. Under permanent deficiencies, for example, one might list a patient with coronary thrombosis or myasthenia gravis. Under temporary deficiencies there would be those who take drugs; those who have serious nervous disorders, the diabetic who suffer from insulin reaction, and others who have not recovered from anesthetics or medical treatment. All of these individuals should be warned of the dangers present for them and others if they drive. There are other examples, of course, too numerous to mention. But in each case the physician is the sole person professionally qualified to judge whether or not the patient's condition will interfere with his driving ability.

Certainly here is an opportunity for the medical profession to render a great service, a service not only to the patient but to all who use the streets and highways.

CONCLUSION

In conclusion, the committee would like to report to the members of the American Medical Association the very prevalent attitude which exists today among the various organizations in the field of safety. We learned that safety men found it extremely encouraging to discover such continuing interest on our part in the traffic accident problem and were certain that our association would be able to make increasingly valuable contributions to the cause of safer driving.

In its course of research and study, the committee was often reminded of one of our heroic predecessors—a man who whipped a disastrous epidemic of cholera in the London of 1854 by the simple expedient of removing the handle from a community pump, the contaminated water of which was the source of the plague. The committee is aware that there is no single "pump handle" which can be removed to whip the traffic accident plague. We must approach the accident epidemic on at least a dozen fronts. There are many "pump handles" to be removed.

However, we of this committee are convinced that at least one of them needs the medical touch. We are equally confident that members of this association will find our particular "pump handle" and provide the initiative necessary to remove it.

Respectfully submitted.

HERMAN A. HEISE, Chairman.

Conference with Board of Trustees of American Hospital Association

The Board of Trustees in its report submitted to the House of Delegates in 1943 referred to conferences held at the Association's offices which were participated in by official representatives of the American Hospital Association, the Catholic Hospital Association and the Protestant Hospital Association. The House of Delegates directed the Board of Trustees to maintain such official contacts with the national hospital associations and adopted the report of the Reference Committee on Reports of Board of Trustees and Secretary which recommended that "the House of Delegates of the American Medical Association urge the American Hospital Association to withhold approval of the uniform comprehensive Blue Cross contract proposed by the Hospital Service Plan Commission of the American Hospital Association which includes certain medical services as a part of hospital care and which, if adopted as recommended by the said commission, would virtually compel the addition of medical services to the benefits of those Blue Cross plans and now accede to the demands of the American Medical Association by confining their benefits to hospital services."

In February 1944 the Board of Trustees participated in a conference with the board of trustees of the American Hospital Association at the offices of the hospital association in Chicago at the invitation of the board of trustees of that organization. At this conference the supplementary report submitted to the House of Delegates in 1943 and the report of the Reference Committee on Reports of Board of Trustees and Secretary as adopted by the House of Delegates were the subjects of prolonged discussion. The outcome of this conference was that committees were appointed to represent the board of trustees of the American Hospital Association and one to represent the Board of Trustees of the American Medical Association. These committees were instructed to undertake to prepare a

statement of principles which might be submitted to the policy making bodies of the two organizations.

At the time this report is being prepared, no meeting of the aforementioned committees has been held, but such a meeting is scheduled for a date in the early part of May, and any statement that may be prepared as a result of the meeting of the committees will be submitted to the House of Delegates if ready for such submission.

Legislative Recognition of Cultists

Resolutions submitted to the House of Delegates at the 1943 meeting by Dr. J. F. Hassig, delegate of the Kansas Medical Society, were referred to the Reference Committee on Medical Education, and a recommendation of that committee that these resolutions be referred to the Board of Trustees was adopted by the House. These resolutions provided "that the proper department of the American Medical Association be suitably expanded to acquire the material and develop suitable means to combat" the legislative recognition of cultists for participation in the practice of medicine and surgery.

The Board of Trustees referred the resolutions to the Council on Medical Education and Hospitals, which has for years undertaken to compile available information pertaining to matters that are directly or indirectly referred to in the resolutions. The Council reported to the Board of Trustees that its members believe that only graduates of approved schools of medicine should be licensed in the practice of medicine, but that it is beyond the function and scope of the Council to attempt to direct action to combat this evil of legislative recognition of cultists to participate in the practice of medicine. This report of the Council is in accord with the report submitted to the House of Delegates by the Reference Committee on Medical Education. The Board of Trustees approved the report of the Council on Medical Education and Hospitals.

Not only has the Council on Medical Education and Hospitals attempted to compile and publish dependable information concerning the theories and educational standards of various cults, but other official agencies of the Association also have concerned themselves with these matters. It should be remembered that each individual state enacts its own laws with respect to licensure, and that in spite of the earnest efforts of the medical profession to maintain the highest possible standards of medical practice and licensure a very considerable number of states have enacted legislation whereby certain cult practitioners may be licensed to practice "medicine and surgery." It seems to be the official attitude of the Congress of the United States that that body cannot go behind the provisions of laws enacted by the sovereign states with respect to who is to be permitted to engage in the practice of medicine.

Up to this time no official representative of the American Medical Association has been permitted to inspect schools for the training of cult practitioners or hospitals in which such practitioners are admitted to serve, with the exception of one instance when the Secretary of the Council on Medical Education and Hospitals was included as a member of a group that was permitted to make a thorough inspection of one osteopathic school.

The American Medical Association has made an earnest effort to prevent the enactment of legislation whereby cultists would be recognized by the federal government on the same basis that recognition is accorded to qualified doctors of medicine. In those instances in which the efforts of the Association in this direction have been unsuccessful, it appears that such recognition as has been given to cult practitioners through official actions of the Congress has been based on the attitude of a majority of the members of Congress voting on such issues that Congress cannot override the laws of the individual sovereign states pertaining to medical licensure.

In recent years the cultists seeking recognition at the hands of Congress apparently have relied more on the possibility of including riders in appropriation bills than on actual enabling legislation.

Resolution Pertaining to a Statement of the Achievements of the Medical Profession with Special Reference to Blindness and Deafness

A resolution submitted to the House of Delegates by Dr. Burt R. Shurly, delegate of the Section on Laryngology, Otology and Rhinology, at the 1943 meeting of the House of Delegates has received official attention from the Board of Trustees.

The Board desires to report to the House of Delegates that progress is being made toward carrying out the provisions of this resolution. The Director of the Bureau of Exhibits has compiled information concerning available motion pictures pertaining to the prevention of deafness and blindness. Articles have been and will be prepared for publication in HYGEIA pertaining to the achievements of medicine.

Through the Joint Committee on Health Problems in Education of the American Medical Association and the National Education Association, constant and effective effort has been exerted to bring to the attention of educators throughout the country the nature of health problems in the solution of which teachers and school administrators can aid and the nature of methods that can be applied in schools for the prevention of disease and for securing proper treatment of existing disease.

For many years members of the official and administrative staffs of the Association have appeared before public audiences, student bodies in schools and colleges and members of various organized groups for the purpose of providing such audiences with dependable information concerning the control of communicable diseases and the application of preventive and curative measures. A considerable amount of printed material in the form of leaflets, pamphlets and brochures, in which the achievements of scientific medicine have been recorded and in which the methods of prevention of disease and its treatment have been set forth, has been distributed.

These educational efforts by the Association will be continued and expanded as opportunity offers.

Communication from Members of Committee on Conservation of Vision

The following communication, signed by Dr. Edward C. Ellett, Chairman, Dr. Harry Gradle and Dr. Lawrence T. Post, members of the Committee on Conservation of Vision, was submitted to the Board of Trustees at a meeting of that body:

Report of a part of the Committee on Conservation of Vision appointed by the Board of Trustees of the American Medical Association.

It is the opinion of the undersigned members of your committee that the problem of the visual care of the people depends on the combined efforts of many elements and that, until free intercourse is established among the representatives of these elements, your committee cannot function successfully.

Since this would involve the formation of a central committee including representatives from such groups as manufacturers of optical goods, opticians, the National Society for the Prevention of Blindness, the Guild of Prescription Opticians, the American Optometric Association and many others, your committee requests authorization in writing to participate in the formation of such a central committee and to carry on such activities as that committee considers within its province be granted to your committee.

Believing that the above is essential to the successful accomplishment of the purpose of this committee, we respectfully request that unless such permission can be granted the committee be discontinued.

This communication is respectfully submitted to the House of Delegates for official consideration.

Conference with Board of Trustees of American Optometric Association

A communication addressed to the Board of Trustees of the American Medical Association by the president and the board of trustees of the American Optometric Association requested that arrangements be made for a conference at which proposals submitted by the American Optometric Association might be considered. Such a conference was held at the offices of the American Medical Association on Nov. 17, 1943, in which the members of the Executive Committee of the Board of Trustees of the American Medical Association and members of the board of trustees of the American Optometric Association participated.

The following statement submitted by the board of trustees of the American Optometric Association through its president, Ewing Adams, O.D., was given very thorough consideration:

Gentlemen:

WHEREAS, According to reasonable estimates, there are in the United States at least thirty to forty million people who need assistance in the correction of faulty vision, either at distant or near points, and other optical aids to the visual functions so that distinct, comfortable and efficient binocular single vision may be maintained; and

WHEREAS, Various surveys show that in the United States there are not enough optometrists, ophthalmologists or specially trained physicians to undertake suitable refraction and examination of the eyes in order to provide properly prescribed lenses and other optical or orthoptic assistance to such persons; and

WHEREAS, There are in the United States in normal times about 7,500 to 8,000 oculists and ophthalmologists and 17,000 optometrists, thereby providing the public with only one practitioner of some type or other who is interested in the care of the eyes and the eyesight of the people to each 6,500 citizens; and

WHEREAS, The foregoing data show that there is great need for visual care and too few practitioners adequately trained and qualified to take care of the visual needs of the people; and

WHEREAS, There are in each of the forty-eight states and in the District of Columbia laws defining and regulating the practice of optometry; and

WHEREAS, There exists in the United States a number of schools of optometry (some as an integral part of recognized universities and others affiliated with such institutions or admitting only those having a specified minimum of collegiate training) which give courses that meet the minimal standard four year curriculum of the Council on Education and Professional Guidance of the American Optometric Association; and

WHEREAS, The present needs of the various armed forces and services of our country and the expanded, speeded-up and more exacting conditions of industry and the vast civilian army of workers at home demand the services of trained optometric refractionists and medical eye specialists in greater degree than heretofore, and that this demand will not be abated subsequent to the cessation of war; and

WHEREAS, It is apparent to many of the leaders in medicine and optometry as well as other groups concerned with the care of the human body that there should be a closer relationship and professional affiliation between these various professional groups in order that there may be established and maintained adequate education, laws, ethical standards and mutually cooperative and supportive measures to the end that the American public may be served properly in matters of health and bodily welfare and in particular as between the professions of medicine and optometry to the end that the eyes and the eyesight of the people of this country may be taken care of in a manner commensurate with the superior services which would be possible under such cooperative action; therefore,

It is an honor and a privilege as well as the great pleasure of the trustees of the American Optometric Association to transmit this communication to the trustees of the American Medical Association, asking that, in the light of the facts and statements made in the preamble, the Board of Trustees of the American Medical Association favorably consider a conference or conferences of its members or such other councils and representatives of the American Medical Association as may seem desirable to them with the trustees or representatives of the Council on Education and Professional Guidance and the Committee on Interprofessional Relations of the American Optometric Association or any groups of them in order to consider and discuss:

1. Optometric education in relation to medical education: proper standards of training for optometrists in the field of vision and of optical technicians in mechanical procedures; proper relationships of practicing optometrists to practitioners of medicine; professional degrees, and such other matters as may be considered germane to the development of suitable standards of education from both medical and optometric viewpoints.

2. Legal and legislative matters: mutual consideration of and cooperation in adequacy and uniformity of legislation and licensure.

3. Ethics: the relationships between the practices of medicine and of optometry with a view to defining suitable relationships in the field of ethical practice between the ethical practitioner of optometry and the ethical practitioner of medicine.

4. Mutual professional respect and support: the broadening of the basis of contact and scope to the end that all practitioners who are concerned with matters of eyes and eyesight and the problems of vision from any corrective or alleviative standpoint may be included in and of necessity become integral parts of such a cooperative association of mutually interested and allied professions and health services.

The representatives of the American Optometric Association were informed that their statement submitted to the Board of Trustees would be brought officially to the attention of the House of Delegates.

Office of the Liaison Officer, Surgeon General of the U. S. Army, and the American Medical Association

Soon after the Association undertook at the request of the Surgeon General of the United States Army to make a comprehensive survey of medical personnel in the United States, the Surgeon General appointed a Liaison Officer, who was assigned to duty in the offices of the American Medical Association. Col. Charles G. Hutter of the Medical Corps of the United States Army was first assigned to this duty. After the declaration of war Colonel Hutter was transferred to active duty in another capacity, and Lieut. Col. Harold C. Lueth became Liaison Officer. The Board of Trustees wishes to make special acknowledgment of the service rendered by Colonel Lueth, which has made available for all proper purposes information in the Association's files that can be used in furthering the active cooperation of the Association with the official agencies of the federal government that are concerned with the prosecution of the war. The Board of Trustees also wishes to acknowledge with gratitude valuable aid extended by Lieutenant Colonel Lueth that has been very helpful in the solution of various problems of concern to the Association in its desire to do everything possible to contribute to the successful prosecution of the war.

CONSULTANT OFFICE OF THE PROCUREMENT AND ASSIGNMENT SERVICE

As has been reported to the House of Delegates on a previous occasion, a consultant office of the Procurement and Assignment Service for Physicians, Dentists and Veterinarians was established in the offices of the American Medical Association in October 1941. Since his assignment as Liaison Officer, Lieutenant Colonel Lueth has been exceedingly helpful in the direction of some phases of the work of this consultant office. A former member of the Bureau of Medical Economics who was eligible for military service received an appointment by the Directing Board of the Procurement and Assignment Service and was assigned to duty in the consultant office.

Through this suboffice of the Procurement and Assignment Service and through the efficient aid of Lieutenant Colonel Lueth, Liaison Officer representing the Office of the Surgeon General of the United States Army, various and valuable compilations of material secured through the survey of medical personnel have been prepared, which not only have been useful for present purposes but also should continue to be useful in various ways for years to come.

Conclusion

All matters that have been referred to the Board of Trustees have received official consideration. The Board of Trustees at this time can report progress only in dealing with some of these matters but will continue to give them official attention until such time as final results can be submitted to the House of Delegates.

The members of the Board of Trustees desire to offer an expression of their appreciation for helpful suggestions that have been received from various sources and for the aid that has been extended to them by members of this House of Delegates and that has come from many other sources. The Board would also commend the members of the various Councils and official committees for their devoted service and express its grateful appreciation of the faithful and efficient service of those of the employees of the Association whose duties in many instances have been faithfully performed in spite of serious difficulties growing out of the war emergency.

Respectfully submitted,

ROGER I. LEE, Chairman.
ERNEST E. IRONS, Secretary.
E. L. HENDERSON.
RALPH A. FENTON.
JAMES R. BLOSS.
CHARLES W. ROBERTS.
EDWARD M. PALLETTE.
R. L. SENSENICH.
WILLIAM F. BRAASCH.

ADDENDA TO REPORT OF BOARD OF TRUSTEES

Report of the Committee on Scientific Research for 1943

Only nineteen applications were received in 1943. Fourteen new grants were made, in all $6,846.57. During the year twenty-eight grants were closed. In six of these grants, the work did not result in any publications, mainly on account of the war. The work under twenty-nine grants prior to 1943 is in progress but in many cases delayed or temporarily suspended by the war. During the year unused balances of grants were refunded in the amount of $1,672.87.

From an anonymous donor $500 was received to be credited to the Charles A. Brant Fund (see report of committee for 1926, THE JOURNAL, April 9, 1927, p. 1165).

FINANCIAL STATEMENT FOR 1943

Balance, Jan. 1, 1943	$ 9,791.98
Appropriation for 1943	13,700.00
Donation to Brant Fund	500.00
Refund, grant 541	67.34
Refund, grant 553	241.90
Refund, grant 582	160.48
Refund, grant 636	422.34
Refund, grant 637	619.65
Refund, grant 638	36.89
Refund, grant 652	124.27
	$25,664.85

GRANTS AND EXPENSES PAID IN 1943

Grant 654, Reginald Fitz	$ 100.00
Grant 655, Arthur M. Lassek	300.00
Grant 656, Warren O. Nelson	300.00
Grant 657, Frederick M. Allen	500.00
Grant 658, Meyer M. Harris	250.00
Grant 659, Deborah V. Dauber (Cardiac Fund)	446.57
Grant 660, Wesley W. Spink	250.00
Grant 661, Roland K. Meyer	500.00
Grant 662, Katharine M. Howell	750.00
Grant 663, L. R. Cerecedo	600.00
Grant 664, S. A. Thompson	550.00
Grant 665, Paul Thomas Young	300.00
Grant 666, Ulrich Friedemann	1,500.00
Grant 667, I. M. Tarlov	500.00
Clerical expense	614.12
	$ 7,460.69
Balance December 31, 1943	$18,204.10

The financial summary for 1943 is presented, also brief accounts of the grants closed during the year, of pending grants from previous years, and a list of the grants made in 1943.

Respectfully submitted.

COMMITTEE ON SCIENTIFIC RESEARCH OF THE AMERICAN MEDICAL ASSOCIATION.

JOHN J. MORTON, Rochester, N. Y.
Term expires, 1948.

E. W. GOODPASTURE, Nashville, Tenn.
Term expires, 1947.

LUDVIG HEKTOEN, Chicago.
Term expires, 1946.

MARTIN H. FISCHER, Cincinnati.
Term expires, 1945.

N. W. JONES, Portland, Ore.
Term expires, 1944.

GRANTS OF COMMITTEE ON SCIENTIFIC RESEARCH

NEW GRANTS—1943

Grant 654: Reginald Fitz, Peter Bent Brigham Hospital, Boston, $100, study of exophthalmic goiter. See grant 635, 1942.

Grant 655: Arthur M. Lassek, Medical College of the State of South Carolina, $300, effect of hemiplegia on the pyramidal tract. See grant 632, 1942.

Grant 656: Warren O. Nelson, Wayne University, $300, lipids in the adrenal cortex.

Grant 657: Frederick M. Allen, New York Medical College, $500, problems of shock. See grant 646, 1942.

Grant 658: Meyer M. Harris, New York State Psychiatric Institute, $250, muscular disease. See grant 648, 1942.

Grant 659: Deborah V. Dauber, Michael Reese Hospital, Chicago, $446.57, atherosclerosis in the chick. (Cardiac Research Fund.) See grant 642, 1942.

Grant 660: Wesley W. Spink, University of Minnesota, $250, staphylococcic infection. See grant 630, 1942.

Grant 661: Roland K. Meyer, University of Wisconsin, $500, antihormones. See grant 612, 1941.

Grant 662: Katharine M. Howell, Michael Reese Hospital, Chicago, $750, amebic dysentery.

Grant 663: L. R. Cerecedo, Fordham University, $600, vitamin B deficiencies in rats and mice. See grant 631, 1941.

Grant 664: S. A. Thompson, New York Medical College, $550, omental grafts in the thorax.

Grant 665: Paul Thomas Young, University of Illinois, $300, food preferences in the rat. See grant 619, 1941.

Grant 666: Ulrich Friedemann, Jewish Hospital of Brooklyn, $1,500, tetanus toxins. See grants 583, 1940, and 653, 1942.

Grant 667: I. M. Tarlov, New York Medical College, $500, regeneration of cauda equina. See grant 634, 1942.

STATE OF GRANT-AIDED WORK

1. GRANTS CLOSED DURING THE YEAR

A. RESULTS PUBLISHED OR READY FOR PUBLICATION

Grant 441, 1937: Edward S. West and G. E. Burget, University of Oregon Medical School, $350, diuretic action and chemical metabolism of sorbitol. Todd, W. R.; Myers, J., and West, E. S.: On the Metabolism of Sorbitol and Mannitol, *J. Biol. Chem.* **127:** 275, 1939. Richardson, Howard L.; Kennedy, James C., and West, Edward S.: Diuretic and Other Effects of Intravenous Sorbitol and Sucrose, *Northwest Med.* **42:** 80, 1943.

Grant 536, 1939: Catharine Macfarlane, Woman's Medical College of Pennsylvania, $1,900, value of periodic pelvic examination in detecting cancer of the uterus. See grant 623, 1942. Macfarlane, Catharine; Fetterman, Faith S., and Sturgis, Margaret C.: Report of an Experiment in the Control of Cancer of the Uterus, *Quart. Rev.*, New York City Cancer Committee, 1941. Macfarlane, Catharine: Progress Report on Experiment in Control of Cancer of the Uterus, *Connecticut State M. J.* **5:** 814, 1941. Macfarlane, Catharine: Precancerous Lesions of Uterine Cervix, *M. Woman's J.*, July 1941. Scott, Eleanor: Analysis of Lesions of the Cervix Discovered in Periodic Pelvic Examinations of 955 Women, *M. Woman's J.*, December 1941. Macfarlane, Catharine; Sturgis, Margaret C., and Fetterman, Faith S.: Report of an Experiment in the Control of Cancer of the Uterus, *Pennsylvania M. J.* **45:** 348, 1942. Macfarlane, Catharine: Why Die from Cancer of the Uterus, *Bull. Am. Soc. Control Cancer* **24:** 2 (Dec.) 1942.

Grant 541, 1939: Henry Laurens, Tulane University, $350, lowering of arterial pressure by carbon arc radiation. Refund $67.34. Laurens, Henry, and Graham, J. S.: The Influence of the Pressure Lowering Effect of Carbon Arc Radiation, *M. Rec.* **154:** 146, 1941. Graham, John S.: Adrenal Cortex and Blood Pressure Response to Carbon Arc Irradiation, *Am. J. Physiol.* **139:** 604, 1943; Effect of Carbon Arc Irradiation and Adrenal Cortical Preparations on Capillary Permeability, *Proc. Soc. Exper. Biol. & Med.* **54:** 101, 1943.

Grant 557, 1939: W. D. Armstrong, University of Minnesota, $500, calcification of bone in vitro. Armstrong, W. D.; Sperling, Louis, and Litow, Sidney: Effect of Phosphoric Acid Esters on Fracture Healing, *Proc. Soc. Exper. Biol. & Med.* **49:** 169, 1942. Sperling, Louis; Armstrong, W. D., and Litow, Sidney: The Influence of Sodium-Beta-Glyceral-Phosphate on the Healing of Experimental Fractures, *J. Bone & Joint Surg.* **24:** 781, 1942.

Grant 574, 1940: A. G. Eaton, Louisiana State University, $300, absorption and metabolism of amino acid. Eaton, A. G., and Doty, J. R.: The Heat Production and Blood and Urine Constituents After Administration of l(—) Histidine to the Dog, *J. Nutrition* **21:** 25, 1941.

Grant 576, 1940: Edward S. West, University of Oregon Medical School, $250, solution of vesical calculi. Rawls, Noel B., and West, Edward S.: Dissolution of Vesical Calculi, *Northwest Med.* **42:** 226, 1943.

Grant 583, 1940: Ulrich Friedemann, Jewish Hospital of Brooklyn, $300, genesis of tetanus. See grants 653, 1942, and 666, 1943. Friedemann, Ulrich, Hollander, A., and Tarlov, I. M.: Investigations of the Pathogenesis of Tetanus: III, *J. Immunol.* **40:** 325, 1941. Friedemann, Ulrich, and Hollander, Alvin: Studies on Tetanal Toxin: I. Qualitative Differences Among Various Toxins Revealed by Bioassays in Different Species and by Different Routes of Injection, *J. Immunol.* **47:** 23, 1943. II. The Antitoxin-Requirements of Tetanal Toxin in the Direct and Indirect Intraventricular Tests, *J. Immunol.* **47:** 29, 1943.

Grant 594, 1940: I. L. Chaikoff, University of California, $350, phospholipid metabolism and blood regeneration as measured by radioactive phosphorus. Fishler, M. C.; Entenman, C.; Montgomery, M. L. and Chaikoff, I. L.: The Formation of Phospholipid by the Hepatectomized Dog as Measured by Radioactive Phosphorus: I. The Site of Formation of Plasma Phospholipids, *J. Biol. Chem.* **149:** 47, 1943.

Grant 595, 1940: Arthur C. Allen, Mount Sinai Hospital, New York, $250, effect of chemicals on vegetations of experimental endocarditis. Refund $148.86. W. J. MacNeal and others: Progressive Lesions of Experimental Endocarditis, *Am. J. Path.* **20:** 95, 1944.

Grant 599, 1941: William H. Welker, University of Illinois College of Medicine, $350, water soluble proteins. Cohen, Harold R.: The Effect of Dry Grinding on the Properties of Proteins: I. Native, Denatured and Coagulated Ovalbumin, *Arch. Biochem.* **2:** 1, 1943.

Grant 603, 1941: Norris J. Heckel, Rush Medical College, Chicago, $250, effect of sex hormones on seminal fluid. Heckel, Norris J., and Steinmetz, Charles R.: The Effect of Female Sex Hormone on the Function of the Human Testis, *J. Urol.* **46:** 319, 1941.

Grant 608, 1941: Everett I. Evans, Medical College of Virginia, $500, problems in surgical shock. Evans, Everett Idris: Studies on Traumatic Shock, I. Blood Volume Changes in Traumatic Shock, *Ann. Surg.*, to be published; Evans, Everett Idris: Studies on Traumatic Shock, II. The Restoration in Blood Volume After Traumatic Shock, *Ann. Surg.*, to be published; Evans, Everett Idris: Studies on Traumatic Shock, III. Anesthesia in Shock, *J. A. M. A.*, to be published.

Grant 612, 1941: Roland K. Meyer, University of Wisconsin, $500, antihormones. See grant 661, 1943. Meyer, R. K.; Kupperman, H. S., and Finerty, J. C.: Increase in Gonadotropic Content of Pituitary Glands of Female Rats Treated with Antigonadotropic Serum, *Endocrinology* **30:** 662, 1942. Marvin, Horace N., and Meyer, Roland K.: Progonadotropic and Aspecific and Aspecific Effects of the Serum of a Horse Immunized with Extracts of Sheep Pituitary Glands, *Endocrinology* **32:** 271, 1943.

Grant 620, 1941: T. T. Chen, University of California, $150, illustrations of malarial parasites. Chen, T. T.: The Nuclei in Avian Malaria Parasites. I. The Structure of Nuclei in Plasmodium elongatum with Some Considerations on Technic, *Am. J. Hyg.*, to be published.

Grant 621, 1941: William M. Cahill, Wayne University College of Medicine, $175, self selection of food in relation to tumor growth. Cahill, W. M.; Dunning, W., and Smith, A. H.: A Free Choice Dietary Study of Tumor-Bearing Rats, *Cancer Research* **3:** 830, 1943.

Grant 624, 1942: Hans Popper, Cook County Graduate School of Medicine, Chicago, $300, vitamin A in tissues. Ragius, Alex B., and Popper, Hans: Variation of Vitamin A Fluorescence in the Cyclic Changes of the Ovary, *Arch. Path.* **34:** 647, 1942; Popper, Hans, and Loeffler, Ernest: Fluorescent Granules at the Glomerular Pole of Human Kidneys, *Proc. Soc. Exper. Biol. & Med.* **53:** 68, 1943; Steigmann, Frederick; Popper, Hans, and Meyer, Karl A.: Liver Function Tests in Clinical Medicine, *J. A. M. A.* **122:** 279, 1943; Meyer, Karl A.; Steigmann, Frederick; Popper, Hans, and Walters, William H.: Influence of Hepatic Function on Metabolism of Vitamin A, *Arch. Surg.* **47:** 26, 1943; Steigmann, Frederick, and Popper, Hans: Intrahepatic Obstructive Jaundice, *Gastroenterology* **1:** 645, 1943; Popper, Hans; Steigmann, Frederick; Meyer, Karl A., and Zevin, S. S.: Relation Between Hepatic and Plasma Concentrations of Vitamin A in Human Beings, *Arch. Int. Med.* **72:** 439, 1943.

Grant 625, 1942: Enid Rodaniche, University of Chicago, $500, study of chemotherapeutic agents on intestinal flora in infectious conditions. Refund $170.73. Rodaniche, E. C., and Palmer, W. L.: The Action of Tyrothricin on Fecal Streptococci in Vitro and in Vivo, *J. Infect. Dis.* **72:** 154, 1943; Rodaniche, Enid: The Fate of the Virus of Lymphogranuloma Venereum in Infected Mice Receiving Sulfonamide Therapy, *J. Infect. Dis.* **73:** 173, 1943.

Grant 627, 1942: Francis J. Braceland, Loyola University School of Medicine, Chicago, $500, carbohydrate disturbances in schizophrenia. Meduna, L. J.; Braceland, F. J., and Vaichulis, John: Diagnostic Difficulties and Levulose Tolerance Test in "Functional" Mental Diseases, *Dis. Nerv. System.* **4:** 101, 1943.

Grant 630, 1942: Wesley W. Spink, University of Minnesota, $300, nutrition and immunology of staphylococci. See grant 660, 1943. Spink, Wesley W.; Vivino, Jean J., and Mickelson, Olaf.: Effects of Cozymase upon Growth of Staphylococci and Antistaphylococcal Action of Sulfonamide Compounds, *Proc. Soc. Exper. Biol. & Med.* **50:** 31, 1942; Spink, Wesley W., and Vivino, Jean J.: Effect of Sulfonamide Compounds upon Staphylocoagulase, *Proc. Soc. Exper. Biol. & Med.* **50:** 37, 1942; Vivino, Jean J., and Spink, Wesley W.: Sulfonamide-Resistant Strains of Staphylococci: Clinical Significance, *Proc. Soc. Exper. Biol. & Med.* **50:** 336, 1942.

Grant 632, 1942: A. M. Lassek, Medical College of South Carolina, $300, retrograde degeneration in the pyramidal tract. See grant 655, 1943. Lassek, A. M.: The Pyramidal Tract, A Study of Retrograde Degeneration in the Monkey, *Arch. Neurol. & Psychiat.* **48:** 561, 1942. Lassek, A. M.: Retrograde Degeneration, Effect of Hemisections on the Homolateral Axons of the Spinal Cord, *Arch. Neurol. & Psychiat.* **49:** 878, 1943.

Grant 633, 1942: Oliver P. Jones, University of Buffalo, $250, effect of antianemic principle on embryonic blood cells. See grant 652, 1942. Jones, O. P.: Mitotic Activity of Primitive Erythroblasts Increased by Administration of Antipernicious Anemia Preparations to Pregnant Rats, *Anat. Rec.* **85:** 321, 1943. Jones, Oliver P.: Morphologic, Physiologic, Chemical and Biologic Distinction of Megaloblasts, *Arch. Path.* **35:** 752, 1943.

Grant 634, 1942: I. M. Tarlov, Jewish Hospital, Brooklyn, $500, study of plasma clot in suture of nerves in monkeys. See grant 667, 1943. Tarlov, I. M.; Goldfarb, Alvin I., and Benjamin, Bernard: A Method for Measuring the Tensile Strength and Stretch of Plasma Clots, *J. Lab. & Clin. Med.* **27:** 1333, 1942. Tarlov, I. M., and Benjamin, Bernard: Plasma Clot and Silk Suture of Nerves. I. An Experimental Study of Comparative Tissue Reaction, *Surg., Gynec. & Obst.* **76:** 366, 1943. Goldfarb, A. I., Tarlov, I. M.; Bojar, S., and Wiener, A. S.: Plasma Clot Tensile Strength Measurement: Its Relation to Plasma Fibrinogen, *J. Clin. Investigation* **22:** 183, 1943. Tarlov, I. M.; Denslow, C.; Swarz, S., and Pineles, D.: Plasma Clot Suture of Nerves: Experimental Technic, *Arch. Surg.* **47:** 44, 1943.

Grant 638, 1942: Charles W. Turner, University of Missouri, $600, mechanism of lactation. Refund $36.89. Meites, Joseph, and Turner, C. W.: Studies Concerning the Mechanism Controlling the Initiation of Lactation at Parturition, *Endocrinology* **30:** 711, 719 and 726; **31:** 340, 1942. Hurst, Victor, and Turner, C. W.: Lactogenic Hormone Content of Anterior Pituitary Gland of Albino Mouse as Compared to Other Species, *Endocrinology* **31:** 334, 1942. Meites, Joseph; Trentin, J. J., and Turner, C. W.: Effect of Adrenalectomy on the Lactogenic Hormone and Initiation of Lactation, *Endocrinology* **31:** 607, 1942. Hurst, V.; Meites, J., and Turner, C. W.: Assay of Adrenals for Lactogenic Hormone, *Proc. Soc. Exper. Biol. & Med.* **49:** 592, 1942.

Grant 640, 1942: Barnett Sure, University of Arkansas, $400, vitamin B complex. See grant 601, 1941. Sure, Barnett: Dietary Requirements for Fertility and Lactation. XXXI. Further Studies on the Role of p-Aminobenzoic Acid and Inositol in Lactation and Growth of the Albino Rat, *J. Nutrition* **26:** 275, 1943.

Grant 642, 1942: Deborah V. Dauber, Michael Reese Hospital, $500, atherosclerosis in the chick. (Cardiac Research Fund.) See grant 659, 1943. Dauber, D. V., and Katz, L. N.: Experimental Atherosclerosis in the Chick, *Arch. Path.* **36:** 473, 1943.

Grant 646, 1942: Frederick M. Allen, New York Medical College, $500, surgical shock. See grant 657, 1943. Allen, Frederick M.: Theory and Therapy of Shock, *Am. J. Surg.* **61:** 79, 1943; Allen, Frederick M.: Experiments on Theory and Therapy of Shock, *Arch. Physical Therapy* **24:** 327, 1943.

Grant 651, 1942: Roger M. Reinecke, University of Minnesota, $300, carbohydrate metabolism of the kidney. Reinecke, Roger M.: The Kidney as a Source of Glucose in the Eviscerated Rat, *Am. J. Physiol.* **140:** 276, 1943.

Grant 657, 1943: Frederick M. Allen, $500, problems of shock. See grant 646, 1942. Allen, Frederick M.: Theory and Therapy of Shock, *Am. J. Surg.* **62:** 80, 1943.

B. No Results Published

Grant 522, 1938: Ludwig A. Emge, Stanford University School of Medicine, $500, relation of sex hormones to tumor growth. Research has been discontinued indefinitely on account of the war service of the grantee.

Grant 533, 1939: Hardy A. Kemp and W. M. Fisher, Baylor University, $500, venom of southern and southwestern scorpions. Refund $241.90. Work discontinued because the war cut off the supply of scorpions.

Grant 611, 1941: M. R. Todd, University of Oregon Medical School, $200, the physiologic effects of canine distemper vaccine. Active research has been suspended on account of the war. Unused balance of $94.84 refunded.

Grant 636, 1942: A. McGhee Harvey, Vanderbilt University School of Medicine, $500, secretion of thymus. Refund $422.34. Work discontinued when grantee enlisted in the Army.

Grant 637, 1942: John R. Paine, University of Minnesota, $620, study of oxygen poisoning. Refund $619.35. Work discontinued on account of the war.

Grant 652, 1942: Oliver P. Jones, University of Buffalo, $570, erythropoietic action of extract of human stomach. See grant 633, 1942. Refund $124.27. Research suspended on account of increased academic duties of grantee.

2. Work in Progress

Grant 479, 1937: Tracy J. Putnam, Boston City Hospital, $200, injuries to the cervical portion of the cord. This research has been suspended for the duration.

Grant 481, 1937: Warren O. Nelson, Wayne University College of Medicine, $200, synthetic androgenic substances.

Grant 504, 1938: Wallace M. Yater, Georgetown University Medical School, $500, histopathology of "bundle branch" block.

Grant 518, 1938: Harold D. West, Meharry Medical College, $100, synthesis of *dl*-threonine. See grant 559, 1939.

Grant 559, 1939: Harold D. West, Meharry Medical College, $50, synthesis of *dl*-threonine. See grant 518, 1938.

Grant 567, 1940: Armand J. Quick, Marquette University, $275, conversion of prothrombin to thrombin. Quick, A. J.: Prothrombin Concentration of the Blood in Various Species, *Am. J. Physiol.* **132:** 239, 1941. Quick, A. J.: Effect of Air Currents on Plasma Prothrombin, *Proc. Soc. Exper. Biol. & Med.* **50:** 317, 1942.

Grant 570, 1940: William H. Sweet, University of Chicago, $300, course of nerve fiber tracts of the temporal lobe.

Grant 571, 1940: Joseph T. King, University of Minnesota, $280, antagonistic effect of tissues on the action of sulfanilamide. Jensen, N. K., and Nelson, M. C.: Local Sulfanilamide in Compound Fractures, *Surg., Gynec. & Obst.* **75:** 34, 1942.

Grant 582, 1940: Charles W. Greene, Stanford University, $500, physiology of the coronary system in monkeys. Refund $160.48.

Grant 584, 1940: Oscar V. Batson, University of Pennsylvania, $200, nystagmus.

Grant 591, 1940: Percival Bailey, University of Illinois, $500, effects of electrolytic lesions in the periaqueductal gray matter of the Macacus monkey. Bailey, Percival, and Davis, E. W.: Effects of Lesions of Periductal Gray Matter in the Cat, *Proc. Soc. Exper. Biol. & Med.* **51:** 305, 1942; The Syndrome of Obstinate Progression in the Cat, *ibid.* p. 307.

Grant 605, 1941: Harry G. Day, Indiana University, $400, physiologic significance of zinc. Active research has been suspended for the duration.

Grant 607, 1941: Fritz Levy, Davis Memorial Hospital, Elkins, W. Va., $250, study of marrow cells.

Grant 609, 1941: C. E. Cahn-Bronner, University of Illinois College of Medicine, $300, bacterial metabolism.

Grant 613, 1941: Robert W. Virtue, University of Denver, $200, formation of cholic acid. [See grant 499, 1938, report for 1940.] Research suspended because grantee is in the Army.

Grant 616, 1941: Robert S. Dow, University of Oregon Medical School, $250, effects of clotting in cerebral veins. See grant 566, 1940.

Grant 617, 1941: Mary Juhn, University of Maryland College of Medicine, $500, tests of applicability of feather germ reaction to tumor diagnosis.

Grant 619, 1941: Paul Thomas Young, University of Illinois, $500, appetites and food preferences in the rat. See grants 641, 1942, and 665, 1942.

Grant 623, 1942: Catharine Macfarlane, Women's Medical College of Pennsylvania, $2,500, value of periodic pelvic and breast examination in detecting cancer. See grant 536, 1939.

Grant 626, 1942: Peter P. H. de Bruyn, University of Chicago, $400, study of osteogenic substance in laying birds.

Grant 629, 1942: Daniel J. Glomset, Des Moines, Iowa, $500, cardiac conduction—disturbances of ventricular conduction.

Grant 631, 1942: L. R. Cerecedo, Fordham University, $500, vitamin B deficiency of rats and mice. See grant 663, 1943.

Grant 635, 1942: Reginald Fitz, Peter Bent Brigham Hospital; Boston, $200, how does hyperthyroidism begin clinically? See grant 654, 1943.

Grant 641, 1942: Paul Thomas Young, University of Illinois, $500, appetite and food preferences in the rat. See grants 619, 1941, and 665, 1943.

Grant 644, 1942: Jacob Rabinovitch, Jewish Hospital, Brooklyn, $240, effect of heparin on thrombosis. Rabinovitch, Jacob, and Pines, Bernard: The Effect of Heparin on Experimentally Produced Thrombosis, *Surgery* **14:** 669, 1943.

Grant 648, 1942: Meyer M. Harris, New York State Psychiatric Hospital, $250, further research on muscular disease. See grant 658, 1943.

Grant 649, 1942: Arthur H. Smith, Wayne University College of Medicine, Detroit, $200, metabolism of citric acid.

Grant 650, 1942: Tuberculosis Committee, Minnesota State Medical Association, J. A. Myers, chairman, $1,000, tuberculosis survey of Meeker County, Minn.

Grant 653, 1942: Ulrich Friedemann, Jewish Hospital, Brooklyn, $750, types of tetanus toxin. See grants 583, 1940, and 666, 1943.

Report of the Committee on Therapeutic Research

The Committee on Therapeutic Research, a standing committee of the Council on Pharmacy and Chemistry, encourages scientific investigations in the field of therapeutics by providing funds for the prosecution of necessary research.

During the year 1943 the committee issued twenty-one new grants. A detailed list of these grants, together with a list of publications during 1943, and of unexpended grants made before Jan. 1, 1943 are included in this report.

The following is a list of the investigations conducted with the assistance of grants made by the Committee on Therapeutic Research, reports of which were published during 1943:

Effects of Certain Analeptic Drugs on Spontaneous Running Activity of the White Rat, M. L. Tainter: *J. Comp. Psychol.* **36:** 143 (Oct.) 1943.

The Stimulant Power of Secondary and Tertiary Phenyl-Isopropyl-Amines, Armando N. Novelli and M. L. Tainter: *J. Pharmacol. & Exper. Therap.* **77:** 324 (April) 1943.

The Lactogenic Hormone and Mammogen, Abraham White: *Ann. New York Acad. Sc.* **43:** 341 (Feb. 26) 1943.

Preparation and Properties of Pituitary Adrenotropic Hormone, George Sayers, Abraham White and C. N. H. Long: *J. Biol. Chem.* **149:** 425 (Aug.) 1943.

Influence of Adrenal Cortical Secretion on Blood Elements, Thomas F. Dougherty and Abraham White: *Science* **98:** 367 (Oct. 22) 1943.

Effect of Pituitary Adrenotropic Hormone on Lymphoid Tissue, Thomas F. Dougherty and Abraham White: *Proc. Soc. Exper. Biol. & Med.* **53:** 132, 1943.

Effect of Pituitary Adrenotropic Hormone on Cholesterol Content of Rat Adrenal Glands, George Sayers, Marion A. Sayers, Abraham White and C. N. H. Long: *Proc. Soc. Exper. Biol. & Med.* **52:** 200, 1943.

Preparation of Pituitary Adrenotropic Hormone, George Sayers, Abraham White and C. N. H. Long: *Proc. Soc. Exper. Biol. & Med.* **52:** 199, 1943.

Staphylococcic Meningitis from Hippocrates to LeGendre and Beaussenat, Ward J. MacNeal, Frances C. Frisbee and Anne Blevins: *Arch. Otolaryng.* **37:** 199 (Feb.) 1943.

Thrombophlebitis of the Cavernous Sinus, Ward J. MacNeal, Frances C. Frisbee and Anne Blevins: *Arch. Ophth.* **29:** 231 (Feb.) 1943.

Bacteriophage Therapy of Staphylococcic Septic Obstruction of the Cavernous Sinus, Ward J. MacNeal, Frances C. Frisbee and Anne Blevins: *Arch. Ophth.* **29:** 341 (March) 1943.

Reported Recoveries from Staphylococcic Meningitis, 1893-1941, Ward J. MacNeal, Francis C. Frisbee and Anne Blevins: *Arch. Otolaryng.* **37:** 349 (March) 1943.

Recoveries from Staphylococcic Meningitis Following Bacteriophage Therapy, Ward J. MacNeal, Frances C. Frisbee and Anne Blevins: *Arch. Otolaryng.* **37:** 507 (April) 1943.

Early Lesions of Experimental Endocarditis Lenta, Ward J. MacNeal, Martha Jane Spence and Alice E. Slavkin: *Am. J. Path.* **19:** 735 (Sept.) 1943.

Effect of Temperature on Urine and Phenolsulfonphthalein Excretion of White Rats at High Altitudes, Herbert Silvette: *Federation Proc.* **2:** 46 (March 16) 1943.

Influence of Postpituitary Extract on the Polyuric Response of White Rats Exposed to Low Barometric Pressure, Herbert Silvette: *Federation Proc.* **2:** 92 (March 16) 1943.

Some Effects of Low Barometric Pressures on Kidney Function in the White Rat, Herbert Silvette: *Am. J. Physiol.* **140:** 374 (Dec.) 1943.

Chlorophyll, An Experimental Study of Its Water Soluble Derivatives in Wound Healing, Lawrence W. Smith and Alfred E. Livingston: *Am. J. Surg.* **62:** 358 (Dec.) 1943.

Magnesium Sulfate in Paroxysmal Tachycardia, Linn J. Boyd and David Scherf: *Am. J. M. Sc.* **206:** 43 (July) 1943.

Metabolism of the Perfused Dog's Brain, Carroll A. Handley, H. Morrow Sweeney, Quinten Scherman and Robert Severance: *Am. J. Physiol.* **140:** 190 (Nov.) 1943.

The Effect of Sodium, Potassium and Thiosulfate Ions on Anaphylaxis, Robert G. Carlson and Richard W. Whitehead: *J. Allergy* **14:** 462 (Sept.) 1943.

A Modern Explanation of the Gastric Emptying Mechanism, J. P. Quigley: *Am. J. Digest. Dis.* **10:** 418 (Nov.) 1943.

Evidence That Body Irritations or Emotions Retard Gastric Evacuation, Not by Producing Pylorospasm But by Depressing Gastric Motility, J. P. Quigley, H. J. Bavor, M. R. Read and B. L. Brofman: *J. Clin. Investigation* **22:** 839 (Nov.) 1943.

Vitamin A and the Toxic Action of Dibenzanthracene on the Tissues, Alfred Goerner and M. Margaret Goerner: *Cancer Research* **3:** 833 (Dec.) 1943.

The Effects of Various Sulfonamide Drugs on the Electrocardiogram of the Dog, Roberta Hafkesbring, Esther M. Greisheimer and Grace E. Wertenberger: *Am. Heart J.* **26:** 333 (Sept.) 1943.

Injections of Gold Sodium Thiosulfate Plus Ultraviolet Irradiation, Otto E. L. Schmidt, Ira C. Evans and William B. Chamberlin Jr.: *Arch. Dermat. & Syph.* **47:** 478 (April) 1943.

Effects of Age and Sex on the Margin of Safety of "Delvinal" Sodium Vinbarbital and of Calcium 5-Ethyl 5-(2-Butyl) N-Methyl Barbituric Acid in the Albino Rat, Harald G. O. Holck, James R. Weeks, Donald R. Mathieson and Beatrice Duis: *J. Am. Pharm. A.* (Scientific Edition) **32:** 180 (July) 1943.

The Sulfonamide Treatment and Clinical Significance of Chronic Biliary Tract Infections, Lester M. Morrison, William A. Swalm, W. Emory Burnett, Frank W. Kunzelmann and Earle J. Spaulding: *Gastroenterology* **1:** 573 (June) 1943.

Intravenous Injections of Soluble Tin Compounds, Joseph Seifter and Edward S. Rambousek: *J. Lab. & Clin. Med.* **28:** 1344 (Aug.) 1943.

Success and Failure of Local Anesthetics, R. Beutner: *Anesth. & Analg.* **22:** 121 (May-June), 205 (July-Aug.) 1943.

Caffeine Withdrawal Headache, Robert H. Dreisbach and Carl Pfeiffer: *J. Lab. & Clin. Med.* **28:** 1212 (July) 1943.

The Effect of Gastrectomy on Growing Monkeys, Smith Freeman, Victor B. Hough, Herman Wigodsky and A. C. Ivy: *Gastroenterology* **1:** 199 (Feb.) 1943.

Seasons and Toxicity of Neoarsphenamine and Sulfanilamide, Alexander J. Nedzel: *Urol. & Cutan. Rev.* **40:** 152 (March) 1943.

The Effect of Diet on the Action of Certain Sulfonamides, Esther M. Greisheimer, Roberta Hafkesbring and Grace E. Wertenberger: *Federation Proc.* **2:** 17 (March 16) 1943.

During 1943 the following grants were made:

Grant 493: J. P. Quigley, Department of Physiology, Western Reserve University School of Medicine, to investigate a reasonably standard type of peptic ulcer which is sensitive to influences hastening or retarding the healing process, $300.

Grant 494: Amedeo S. Marrazzi, professor of pharmacology, Loyola University School of Medicine, to investigate sympathomimetic amines, $500.

Grant 495: Harry Beckman, professor of pharmacology, Marquette University School of Medicine, to investigate continuous quinine administration in experimental malaria infections, $250.

Grant 496: W. F. Hamilton, professor of pharmacology and physiology, University of Georgia School of Medicine, to investigate the intravascular pressures of unanesthetized animals and man by means of the hypodermic manometer, $125.

Grant 497: E. Ross Hart, assistant professor of pharmacology, Jefferson Medical College of Philadelphia, to investigate the pharmacologic properties of N-allyl-normorphine and related compounds, $250.

Grant 498: Linn J. Boyd, director of medicine, and Kurt Lange, clinical instructor in medicine, New York Medical College, to investigate the effect of cold in the treatment of shock, $300.

Grant 499: Joseph Litwins, clinical instructor in medicine, New York Medical College, to investigate the chemistry and hematology of blood donors, $200.

Grant 500: W. J. MacNeal, director of the Laboratories of Bacteriology, New York Post-Graduate Medical School and Hospital, to investigate experimental viridans endocarditis, $400.

Grant 501: W. J. MacNeal, director of the Laboratories of Bacteriology, New York Post-Graduate Medical School and Hospital, to investigate the bacteriophage phenomenon and therapeutic application of bacteriophages, $400.

Grant 502: Julian P. Maes, Department of Pharmacology, Dartmouth College, to investigate the part played by the red blood corpuscle concentration of the systemic circulation in the mainteuance of blood pressure at different levels of vasoconstrictor tone, $150.

Grant 503: A. T. Miller Jr., assistant professor of physiology, University of North Carolina School of Medicine, to investigate the factors concerned in individual differences in susceptibility to anoxia, $250.

Grant 504: Thomas G. Morrione, Long Island College of Medicine, to investigate the deranged estrogen metabolism accompanying cirrhosis of the liver, $250.

Grant 505: James Orten, assistant professor of physiologic chemistry, Wayne University College of Medicine, to investigate the relationship of dietary protein to porphyrin metabolism in the rat, $250.

Grant 506: Andrew F. Burton, assistant professor of pharmacology, Howard University, to investigate (1) the distribution of sulfanilamide in maternal and fetal tissues at various stages of pregnancy; (2) the toxic effects of quinine on the fetus in utero, $600.

Grant 507: J. Max Little, assistant professor of physiology and pharmacology, and R. E. Miller, Wake Forest College, to investigate the suitability of gelatin as a blood substitute, $400.

Grant 508: Lawrence W. Smith, professor of pathology, Temple University Medical School and Hospital, to investigate the optimal combinations of sulfonamides and of chlorophyll for the healing of infected wounds, $500.

Grant 509: Thomas H. McGavack, associate professor of medicine, New York Medical College, to investigate water balance under the influence of various hormones, $350.

Grant 510: Louis S. Goodman, chairman Department of Pharmacology and Physiology, University of Vermont College of Medicine, to investigate benzimidazole in comparison with other central nervous system depressants, $800.

Grant 511: K. A. C. Elliott, Chemical Research Laboratory, Institute of the Pennsylvania Hospital, to investigate the effects of low and high oxygen tensions on brain metabolism, $500.

Grant 512: Essie White Cohn, associate professor of chemistry, University of Denver, to investigate the effect of sulfonamide drugs on the glycogen content of the liver of rabbits and rats, $200.

Grant 513: Ruth E. Miller, professor of bacteriology, Woman's Medical College of Pennsylvania, to investigate the relationship between immune mechanisms and bacterial respiration, $412.50.

The following grants were issued before Jan. 1, 1943. In some cases the grant has expired and an unexpended balance remains; or the work is not yet completed, or not yet published.

Grant 164: E. L. Jackson, associate professor of pharmacology, Emory University School of Medicine, to investigate the antagonism between sodium barbital and insulin, $200.

Grant 232: George R. Cowgill, associate professor of physiologic chemistry, Yale University School of Medicine, to investigate the heart in vitamin B deficiency, $250.

Grant 238: Roy R. Kracke, professor of pathology, Emory University School of Medicine, to investigate the effect of the oxidation products of aminopyrine and related drugs on the leukocyte counts of rabbits, $250.

Grant 280: John P. Peters, professor of medicine, Yale University School of Medicine, to investigate by means of intravenous pyelography the state of ureters and kidneys in a large series of patients after delivery and subsidence of acute signs of toxemia, $200.

Grant 297: Melvin Dresbach, Harvard Medical School, to investigate the emetic effect of some of the digitalis bodies, $250.

Grant 306: Edwards A. Park, professor of pediatrics, Johns Hopkins University School of Medicine, to investigate rickets in the rat and the effect of solution of parathyroid on the circulation of the bone, $75.

Grant 355: Peter K. Knoefel, associate professor of pharmacology, University of Louisville School of Medicine, to investigate the action of amines, of the epinephrine series and of related substances on the central nervous system, $150.

Grant 391: A. R. McIntyre, professor of physiology and pharmacology, University of Nebraska College of Medicine, to investigate ouabain and cardiac muscle and metabolism, $100.

Grant 408: Ephraim Shorr, assistant professor of medicine, Cornell University Medical College, to investigate the effect of progesterone on the vaginal smear, $300.

Grant 412: Ann Forbes, Massachusetts General Hospital, Boston, to investigate the effect of various endocrine diseases and the administration of various endocrine products on the 17-keto-steroid secretion in the urine, $400.

Grant 430: J. P. Simonds, Department of Pathology, Northwestern University Medical School, to investigate the selective action of different types of poisons on the kidneys, $100.

Grant 443: A. B. Baker, assistant professor of neuropsychiatry and neuropathology, and Raymond N. Bieter, professor of pharmacology, University of Minnesota Medical School, to investigate toxic effects of sulfanilamide and derivatives on nervous system and effect of vitamin B complex in prevention of such injuries, $500.

Grant 445: Paul L. Day, professor of physiologic chemistry, and John R. Totter, instructor in physiologic chemistry, University of Arkansas School of Medicine, to investigate ocular manifestations of tryptophan deficiency, $300.

Grant 449: Alrick B. Hertzman, professor of physiology, St. Louis University School of Medicine, to investigate peripheral circulation, $500.

Grant 454: W. L. Mendenhall, professor of pharmacology, and Albert J. Plummer, assistant professor of pharmacology, Boston University School of Medicine, to investigate the quantitative determination of theophylline, $50.

Grant 455: Frederick H. Pratt, professor of physiology, and Marion A. Reid, instructor in physiology, Boston University School of Medicine, to investigate the effect of cardiac drugs on the denervated lymphatic hearts, $100.

Grant 457: Leland C. Wyman, associate professor of physiology, Boston University School of Medicine, to investigate the factors controlling the growth and functional efficiency of transplanted adrenal cortical tissue, $372.50.

Grant 458: George Fahr, professor of internal medicine, University of Minnesota, to investigate the effects of lanatoside C on certain types of heart disease, $100.

Grant 459: Mary E. O'Sullivan, Bellevue Hospital, New York City, to investigate the therapeutic effect of estradiol in muscular dystrophy, $100.

Grant 462: B. K. Harned, professor of pharmacology, Versa V. Cole, associate professor of physiology, and Hughbert C. Hamilton, associate professor of physiology, Women's Medical College of Pennsylvania, to investigate the effects of bromide administered to pregnant rats on the learning ability of the offspring, $288.

Grant 467: R. C. de Bodo, associate professor of pharmacology, New York University College of Medicine, to investigate the antidiuretic action of the narcotics, $500.

Grant 472: Robert V. Brown, associate professor of physiology and pharmacology, University of North Dakota, to investigate action of pilocarpine on bile secretion, $150.

Grant 473: Richard C. de Bodo, associate professor of pharmacology, New York University College of Medicine, to investigate temporary and permanent effects of insulin on carbohydrate metabolism with special reference to its effects on adrenalin hyperglycemia and liver glycogenolysis, $500.

Grant 474: Arthur C. DeGraff, professor of therapeutics, New York University College of Medicine, to investigate the effectiveness of sodium thiosulfate and sodium formaldehyde sulfoxalate in treatment of cardiac arrhythmias induced experimentally by mercurial diuretics, $400.

Grant 477: Harold C. Hodge, assistant professor of biochemistry and pharmacology, University of Rochester School of Medicine and Dentistry, to investigate acute toxicity of choline, $200.

Grant 478: Stacy R. Mettier, associate professor of medicine, University of California Medical School, to investigate the Rh factor in blood transfusion and other immunologic aspects of blood grouping, $400.

Grant 479: Mayo H. Soley, assistant professor of medicine and pharmacology, University of California Medical School, to investigate treatment of patients with toxic diffuse goiter by means of radioactive iodine, $350.

Grant 483: Donald Slaughter, professor of pharmacology and physiology, Southwestern College of Medicine, to investigate the effects of sulfonamides on the regeneration of visual purple, $150.

Grant 484: Alfred Goerner, associate professor of biologic chemistry, Long Island College of Medicine, and M. Margaret Goerner, pathologist, Brooklyn Thoracic Hospital, to investigate the toxic action of carcinogenic compounds on liver tissue, $400.

Grant 485: Carl W. Walter, Laboratory of Surgical Research, Harvard Medical School, for construction of a hydrogen ion potentiometer to be used for studies on (*a*) the mobilization and deposition of bone calcium by electrolysis; (*b*) animal tissue response to metallic magnesium and its alloys, $250.

Grant 488: L. R. Kaufman, director of surgery, New York Medical College, to investigate circulatory competence of the gut in cases of intestinal obstruction, $125.

Grant 489: L. R. Kaufman, director of surgery, New York Medical College, to investigate the use of enzyme mixture for dissolving slough, $100.

Grant 490: Andrew F. Burton, assistant professor of pharmacology, Howard University School of Medicine, to investigate the distribution of sulfanilamide and the toxic effects of quinine, $698.

Grant 491: Fred D. Weidman, vice dean for dermatology and syphilology, University of Pennsylvania Graduate School of Medicine, to investigate the control of dermatophytosis and value of living Bacillus subtilis cells, $500.

Grant 492: Abraham White, assistant professor of physiologic chemistry, Yale University School of Medicine, to investigate the hormones of the anterior pituitary gland, $200.

TREASURER'S REPORT

Report of the Treasurer of the American Medical Association for the Year Ended December 31, 1943

Investments (At Cost) as at January 1, 1943		$2,541,309.16
Bonds Purchased (At Cost)		913,157.30
		$3,454,466.46
Less:		
Bonds Called, Matured or Sold	196,335.13	
Investments as at December 31, 1943		$3,258,131.33
Balance for Investment January 1, 1943	121,296.23	
Interest Received on Investments	86,603.78	
Uninvested Funds December 31, 1943		207,900.01
Invested and Uninvested Funds as at December 31, 1943		$3,466,031.34

DAVIS MEMORIAL FUND

Balance in Fund January 1, 1943	$7,614.03
Interest Earned on Bank Balance Year 1943	95.46
Funds on Deposit as at December 31, 1943	$7,709.49

JOSIAH J. MOORE, Treasurer.

AUDITOR'S REPORT

February 3, 1944.

To the Board of Trustees,
American Medical Association, Chicago, Illinois.

Dear Sirs:

We have examined the balance sheet of the American Medical Association, Chicago, Illinois, as of December 31, 1943, and the statement of income for the year ended on that date, have reviewed the system of internal control and the accounting procedures of the Association and, without making a detailed audit of the transactions, have examined or tested accounting records and other supporting evidence, by methods and to the extent we deemed appropriate except as hereinafter stated regarding confirmation of receivables and observation of the inventory taking.

The cash and back balances have been confirmed by count or by certificates from the depositaries. The United States Government and other marketable securities were confirmed by an acknowledgment from the Continental Illinois National Bank and Trust Company of Chicago where the securities are held for safekeeping.

We did not independently confirm the accounts receivable by communication with the debtors. The accounts receivable were reviewed as to age and collectibility and, in our opinion, the balances are fully realizable. We reviewed the plan and system of control adopted for inventory taking but we did not observe the taking of the inventories nor did we make tests of the physical existence of the quantities recorded.

Expenditures charged to property and equipment accounts during the year, in our opinion, were properly capitalized as representing additions or improvements. The provision for depreciation for the year appears to be adequate.

In our opinion, subject to the exceptions set forth in paragraph three, the accompanying balance sheet and related statement of income present fairly the position of the American Medical Association at December 31, 1943, and the results of the operations for the year, based on the accounting procedures employed by the Association regarding which the following observations are submitted:

(a) In accordance with the established practice of the Association, the accounts as stated do not include (a) unrecorded assets in respect of accrued interest on bond investments, and membership dues unpaid; and (b) provision for accrued property taxes for the year 1943, and sundry unpaid bills and wages.

(b) Subscriptions paid in advance are stated at an estimated amount which is based on cash received in December 1943, on account of 1944 subscriptions. This procedure conforms to the method used in prior years.

(c) Advance payments on publications include an estimated amount ($131,329.53) for prepaid subscriptions to Hygeia, and the amount ($44,876.43) received in advance for January 1944, advertising, directory information sales and service.

We have received a letter from Messrs. Loesch, Scofield, Loesch and Burke, attorneys for the Association, regarding litigation pending against the Association or its officers at December 31, 1943, which states that the following law suits had been filed:

Jean Paul Fernel	$1,000,000 (libel)
L. E. Polhemus	50,000 (claim)

The attorneys state that in their opinion these suits will be defeated.

Fidelity insurance is carried against the undermentioned officers and employees, in the amounts stated:

Dr. Olin West, Secretary and General Manager	$10,000.00
Dr. Josiah J. Moore, Treasurer	10,000.00
E. A. Hoffman, Cashier	10,000.00
J. E. Hartigan, Assistant Cashier	2,000.00
Sundry employees (ten, $1,000.00 each)	10,000.00
Total Fidelity Insurance	$42,000.00

We have pleasure in reporting that the books are well maintained and that every facility was afforded us for the proper conduct of the examination.

Yours truly,

PEAT, MARWICK, MITCHELL & Co.

INDEX TO STATEMENTS

	Exhibit
Balance Sheet as of December 31, 1943	"A"
Income Account for the year ended December 31, 1943	"B"
	Schedule
Publications (Periodicals)—Costs and Expenses for the year ended December 31, 1943	"1"
Expenses of Councils, Bureaus and Committees for the year ended December 31, 1943	"2"

EXHIBIT "A"

BALANCE SHEET

AS OF DECEMBER 31, 1943

ASSETS:		
Property and Equipment—at cost:		
Land		$ 328,773.98
Buildings	$1,375,349.31	
Machinery and printing equipment	492,613.08	
Office and laboratory equipment	196,727.67	
	2,064,690.06	
Less—Reserve for depreciation	993,431.18	1,071,258.88
Type metal (book inventory)—at average cost		22,682.05
Total Property and Equipment		1,422,714.91
Marketable Securities—at cost (valuation based on market quotations $3,340,311.31):		
United States Government securities	2,121,365.63	
Railroad, municipal, industrial and public utility bonds	1,136,765.70	3,258,131.33
Representing investments of:		
General fund	933,131.33	
Association reserve fund	350,000.00	
Retirement reserve fund	525,000.00	
Building reserve fund	450,000.00	
Depreciation reserve fund	1,000,000.00	
Cash Held by Treasurer for Investment		207,900.01
Cash in Banks and on Hand		499,973.12
Accounts Receivable:		
Advertising	124,794.09	
Reprints	2,655.31	
Directory Report Service, 18th Edition	1,118.53	
Miscellaneous accounts receivable	1,722.02	130,289.95
Inventories of Materials, Supplies, Work in Progress and Publications		104,758.38
Expenditures on Publications in Progress		74,737.85
Prepaid Expenses, Deposits and Advances:		
Insurance, etc.	5,870.66	
Deposits and advances	7,476.96	13,347.62
Total		$5,711,853.17
LIABILITIES:		
Accounts Payable:		
Cooperative Medical Advertising Bureau	$ 19,943.45	
Miscellaneous	24,167.60	
Total Accounts Payable		$ 44,111.05
Subscriptions Paid in Advance		61,447.08
Advance Payments on Publications		176,205.96
Net Worth:		
Association reserve	350,000.00	
Building reserve	450,000.00	
Retirement reserve	525,000.00	
Capital account:		
Balance at December 31, 1942	$3,786,215.32	
Add—Net income for the year ended December 31, 1943	718,873.76	
	4,505,089.08	
Deduct—Amount transferred during year to retirement reserve	400,000.00	4,105,089.08
Net Worth, December 31, 1943		$5,430,089.08
Total		$5,711,853.17

EXHIBIT "B"

INCOME ACCOUNT

FOR THE YEAR ENDED DECEMBER 31, 1943

Income:		
Fellowship dues		$ 64,883.00
Income from investments		82,744.08
Miscellaneous receipts and other income		21,736.80
		169,363.88
Publications—Periodicals:		
Subscriptions	$1,235,677.33	
Advertising	1,366,659.10	
	2,602,336.43	
Costs and expenses—Schedule "1"	1,628,969.06	973,367.37
Books, Pamphlets and Reprints Sold	131,923.52	
Less—Printing and other costs	88,110.51	43,813.01
Total Income		$1,186,544.26
Expenses:		
Conducting Councils, Bureaus and Committees —Schedule "2"	432,895.96	
Legal and investigating	10,668.21	
Miscellaneous	24,106.33	467,670.50
Income in Excess of Expenses		$ 718,873.76

SCHEDULE "1"

PUBLICATIONS (PERIODICALS)—COSTS AND EXPENSES

FOR THE YEAR ENDED DECEMBER 31, 1943

Wages and salaries		$ 790,582.11
Paper		287,253.84
Engravings and illustrations		30,310.47
Ink		13,955.61
Factory and mailing supplies		20,917.94
Repairs and renewals—machinery		2,440.73
Express and cartage		10,259.18
Power and light		14,504.83
Building expense		40,481.03
Fuel		9,171.69
Insurance and taxes		31,993.42
Editorials, news and reporting		11,713.62
Postage—first class		45,303.22
Postage—second class		73,659.05
Commissions—subscription and advertising		94,851.46
Discounts		52,783.56
Exchange		1,576.12
Subscription promotion expense		14,482.35
Office supplies		11,029.60
Telephone and telegrams		4,265.71
Office printing		27,642.08
Binding		3,859.05
Miscellaneous operating expenses		22,811.78
Group hospital insurance		2,399.04
Loss (profit) on sale of equipment, bad debts and recoveries—net		4,306.56
Loss on metal dross sales		1,010.17
		1,614,951.10
Depreciation (based on estimated remaining life):		
Buildings	$23,133.80	
Machinery	13,758.30	
Type and factory equipment	1,197.45	
Furniture and equipment	6,528.37	44,817.92
		1,659,769.02
Deduct—Proportion of overhead expenses charged to other publications and departments		30,799.96
Total Publications (Periodicals)—Costs and Expenses		$1,628,969.06

NOTE: Total wages and salaries for year 1943 amounted to $1,202,472.14. Of this amount $790,582.11 is included above, $274,349.34 is shown in schedule "2" (expenses of Councils, Bureaus and Committees), and the remainder, $137,540.69, was disbursed in connection with the 18th edition of the American Medical Directory, now in preparation, and with the printing of books, reprints and pamphlets, and printing in process at the close of the year.

SCHEDULE "2"

EXPENSES OF COUNCILS, BUREAUS AND COMMITTEES

FOR THE YEAR ENDED DECEMBER 31, 1943

Salaries and wages	$274,349.34
Office printing	14,994.39
Office supplies and repairs	4,698.94
Express, telephone and telegraph	3,565.72
Postage	6,098.84
Binding	663.80
Books and periodical subscriptions	611.24
Educational material distributed	7,730.99
Travel	14,137.97
Radio broadcasting	11,525.34
Inspection of hospitals and medical schools	4,432.53
Association exhibits	6,828.12
Trustees' meeting expenses	7,162.83
Consultations, investigations, tests and honorariums	11,635.42
Section secretaries' conference and honorariums	3,089.21
State secretaries' conference	6,404.89
Council and bureau conferences	11,737.42
Committee on Scientific Research	5,287.82
Committee for War-time Graduate Medical Meetings	20,000.00
Other committee expenses	4,998.21
Miscellaneous	12,942.94
Total Expenses of Councils, Bureaus and Committees	$432,895.96

NOTE: The above expenses are spread over the following councils, bureaus and committees as indicated: Association account $125,297.25; Bureau of Health Education, $40,075.25; Council on Pharmacy and Chemistry, $44,510.63; Chemical Laboratory, $14,439.95; Council on Physical Therapy, $15,724.02; Council on Foods, $11,563.10; Committee on Therapeutic Research, $6,944.42; Council on Medical Education and Hospitals, $61,954.36; Bureau of Legal Medicine and Legislation, $32,692.28; Bureau of Investigation, $9,594.17; Bureau of Medical Economics, $19,816.24; Council on Industrial Health, $23,424.16; Bureau of Exhibits, $13,550.66; Council on Medical Service and Public Relations, $2,141.83; Committee on Medical Preparedness, $11,167.64.

REPORT OF THE JUDICIAL COUNCIL

To the Members of the House of Delegates of the American Medical Association:

There has been little activity on the part of the Judicial Council during the past year. With a large portion of our members engaged in war service, leaving the patient populace in the care of those at home, nearly all physicians have been burdened almost beyond capacity. No difficult or controversial problems have come before the Council. Inquiries have been handled by correspondence. Problems discussed by the Council, in session, have been confined largely to questions regarding Fellowship in the Association. These questions have uniformly had their origin in a lack of familiarity with the Principles of Medical Ethics. We must accordingly conclude that a large portion of our membership regards the printed Principles of Medical Ethics as a complicated document to be interpreted only by experts, as each individual question arises!

At various times, resolutions have been presented in the House of Delegates directing the Judicial Council or an appointed committee to rewrite or more precisely define our Principles of Medical Ethics, giving illustrations of unethical action which would guide the ethical judgment of the membership.

Such revision of the Principles of Medical Ethics is not the answer to this problem. To illustrate or elucidate would only produce "confusion worse confounded." Rather let us firmly identify in our minds these dictionary definitions:

(*a*) "A Law is a rule of action established by recognized authority to enforce justice and prescribe duty."

(*b*) "A Principle is (1) a general truth, (2) a settled law or rule of action, especially right action, consciously adopted."

(*c*) "Ethics is the basic principle of rules of right action."

Law which is punitive in action deals only with a specific crime or misdemeanor and must be so particularly applied (witness the row upon row of tomes necessary to the lawyer's library) as to permit no loopholes for evasion. The American Medical Association has no laws to compel its membership to care for the sick or the public at large. That would be foreign to our conception of the Principles of Medical Ethics, which reflect our pride in "a rule of right action, consciously adopted."

The Principles of Medical Ethics are broad and permanent. They are intended to be a guide to right action. Conditions vary with different sections of the country. A physician may be almost inaccessible to people in some isolated areas, and the opposite be true in a more populous region. What may constitute ethical conduct of the physician in one section might be distinctly unethical in a section characterized by a differing set of circumstances. This is the reason for the broad application of the Principles of Medical Ethics toward one definite point—the welfare of the patient. It is the full knowledge of the conditions surrounding the patient—not the doctor—that determines whether a practice is ethical or unethical.

Many of the difficulties in interpreting the Principles of Medical Ethics are related to the physician's income from his practice. This is covered in the first sentence of that thin little booklet which should be in the possession of every physician from the moment of his graduation: "A profession has for its prime object the service it can render to humanity; reward or financial gain should be a subordinate consideration." Truly this is a broad statement but, when conscientiously applied, dispels difficulty!

The time is approaching when those of our profession who are now in war service will be coming back home. They will return to a shattered clientele who have drifted away or who of necessity have been treated by physicians remaining at home. Chapter III, article IV, of the Principles of Medical Ethics provides for this contingency:

SEC. 4.—When a physician does succeed another physician in the charge of a case, he should not make comments on or insinuations regarding the practice of the one who preceded him. Such comments or insinuations tend to lower the esteem of the patient for the medical profession and so react against the critic.

SEC. 7.—When a physician is requested by a colleague to care for a patient during his temporary absence, or when, because of an emergency, he is asked to see a patient of a colleague, the physician should treat the patient in the same manner and with the same delicacy as he would have one of his own patients cared for under similar circumstances. The patient should be returned to the care of the attending physician as soon as possible.

SEC. 8.—When a physician is called to the patient of another physician during the enforced absence of that physician, the patient should be relinquished on the return of the latter.

These are representative problems repeatedly presented. They serve, in an uneasy period preceding the inevitable postwar confusion, to remind every member of the American Medical Association of the bulwark of safety in his knowledge of the Principles of Medical Ethics.

Respectfully submitted.

GEORGE EDWARD FOLLANSBEE, Chairman.
EDWARD R. CUNNIFFE.
WALTER F. DONALDSON.
LLOYD NOLAND.
JOHN H. O'SHEA.

REPORT OF THE COUNCIL ON MEDICAL EDUCATION AND HOSPITALS

To the Members of the House of Delegates of the American Medical Association:

During the past year important problems relating directly to the wartime programs of medical and premedical education and house officer training have concerned the Council, in addition to numerous problems not primarily pertaining to the war.

THE WARTIME MEDICAL SCHOOL PROGRAMS

All medical schools in the United States (including the schools of basic medical sciences) are on the accelerated program. One school is on an accelerated program for only the junior and senior years. All but two schools are admitting classes every nine months, one admitting some students approximately every three months and one admitting annually.

As a combined result of acceleration and of the shortened internship, several hundred men are now on active duty in the Army and Navy Medical Corps who would ordinarily still be interning. These men commenced their senior year three months early in July 1942, graduated in March 1943 and completed the nine months internship in December 1943. Under the normal program they would remain in internships until July 1, 1944.

During the calendar year 1943 most schools graduated two classes, chiefly in March and December. In 1944 and 1945 most schools will graduate but one class. The average number of annual graduates will approximate 7,000, which is far in excess of the number graduating at any previous time. In 1905, when there were 160 medical schools in operation in this country, there were 5,606 graduates.

At the outset of the war, medical schools were advised to increase enrolments by 10 per cent, when this could be done without lowering standards. It is now apparent that some schools have increased their enrolments well beyond 10 per cent and probably beyond the point warranted by the available facilities.

The reduction in teaching staffs has increased in the past year. At the last estimate there were approximately 6,000 faculty members in service. Although this includes some men who are not physicians, it seems probable that about 10 per cent of the medical officers in the armed forces have come from faculties of medicine, which include in the neighborhood of 10 per cent of the physicians of the country. The interpretation and evaluation of these data are difficult, since many if not most of the teachers now in active service were on a part time basis, in some instances contributing only an hour or two a week to instruction. Yet it is apparent that medical schools seem to have contributed approximately as large a proportion of their faculty members to the armed forces as the proportion of physicians not engaged in scientific work who have been commissioned.

There seems to be little question that the major difficulty in maintaining adequate educational standards has been the depletion of teaching staffs. This factor exceeds in importance any deleterious effects of the accelerated program. Threats to the quality of training also lie in the unwarranted increases in enrolments in some schools and the chronic state of uncertainty in which students have found themselves, with the frequent changes that have occurred and continue to occur with respect to their medical education.

THE ARMY SPECIALIZED TRAINING PROGRAM

When it was announced that the Army Specialized Training Program was to be drastically reduced in all fields, the Council stated to the Secretary of War, the Surgeon General of the Army and the Army Specialized Training authorities that failure to provide for a constant flow of qualified students into and through the medical schools would jeopardize civilian care even if Army replacements were adequate.

The authorities decided in February that men then in medical and premedical Army Specialized Training Programs would be continued as originally planned.

Whether this ruling will enable the Army to fill the anticipated 55 per cent of freshman places in medical schools even in the late 1944 and early 1945 classes is open to question. Premedical students already accepted for those classes who are now under Selective Service deferment must complete their premedical and medical courses under deferment as civilians.

Under the present plans, qualified high school graduates under 18 years will enter the Army Specialized Training Reserve Program as premedical civilians with army scholarships. If qualified, these men will be transferred to an advanced level in the Army Specialized Training premedical program on active duty as soldiers in school on reaching the age of 18, completion of basic military training and passing a medical aptitude test. This Army Specialized Training Program will be curtailed in numbers, so that from mid-1945 on the Army will probably provide the schools with about one-half the numbers of entering freshmen originally contemplated.

There may also be assigned to medical schools under the Army Specialized Training Program a limited number of qualified soldiers, provided they have performed well in the Army-Navy (A-12,V-12) College Qualifying Test and have already completed an academic year of premedical work as civilians.

From these sources the Army will scarcely be able to supply the medical schools with half the anticipated members. With the Navy's 25 per cent of places in freshman classes, this means that about half of our premedical and medical students must be civilians. There is considerable doubt whether Selective Service will provide for deferment of these students. Even if it should do so, many qualified men will choose active duty in the Army to academic studies, and it will be difficult to fill the places in entering classes with qualified students.

THE NAVY V-12 PROGRAM

No change is contemplated in the Navy V-12 program for premedical and medical students. There is a sufficient number of men in premedical training to enable the Navy to continue to meet its commitments of 25 per cent of the places in entering and advanced classes in medical schools.

THE 9-9-9 AND QUOTA PROGRAMS FOR HOUSE OFFICERS

Effective Jan. 1, 1944 the internship was limited to nine months for all officers. A maximum of one third of these may be deferred for an additional nine months as assistant residents. One half of the assistant residents may be deferred for a third nine month period as residents. This program was proposed by the Procurement and Assignment Service as more desirable than the only available alternative, which was a twelve month internship for all medical officers, with no further deferments for any of them, so that house officers beyond the intern level would be limited to women and physically disqualified men. The latter was the only plan other than the 9-9-9 program to which the Surgeons General of the Army and Navy would agree.

The Council on Medical Education and Hospitals agreed to the 9-9-9 plan, realizing it to be educationally highly undesirable but also recognizing it as the best available under prevailing conditions.

The Procurement and Assignment Service also allotted quotas of house officers to each state and to each hospital within the state. The quotas were set at 60 per cent of the house officers on duty in hospitals in 1940, as shown by the reports of the Council on Medical Education and Hospitals. Due allowances were made for teaching hospitals and other pertinent factors, including increases in hospital admissions above 1940 in excess of the national overall increase of 14 per cent. Minor adjustments in these quotas were permitted at the state level, but it was urged that the quotas originally assigned should be departed from as little as possible.

The establishment of the quotas and the inauguration of the 9-9-9 program necessitated rapid adjustments by hospitals and house officers late in 1943. This was effected with less difficulty than was expected by many, largely as the result of the whole-hearted cooperation of all concerned.

At the request of the Procurement and Assignment Service, the Council on Medical Education and Hospitals served as a clearing house for hospitals with unfilled quotas and house officers lacking appointments. This was effected through weekly publications of lists of hospitals needing house officers in THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

POSTWAR EDUCATIONAL FACILITIES FOR RETURNING MEDICAL OFFICERS

Over a year ago the Council embarked on a preliminary study of postwar educational facilities which will be available to returning medical officers. Information was sought from nearly 1,300 institutions and agencies, including hospitals, medical schools, departments of health, state medical associations and examining boards in medical specialties. A preliminary report of the findings was published in THE JOURNAL on Jan. 1, 1944. Refresher and review courses, postgraduate lecture and clinic series, and internships and residencies are being developed in many fields in numbers which give fair promise of meeting the probable demand from returning officers as well as from the more recent graduates who will not have been on active duty.

This study of postwar educational facilities will be continued, so that even before the close of the war the Council expects to have ready for distribution a printed list of all educational opportunities available to returning medical officers and especially planned for them.

In the Council's planning for these postwar services it became clear early that we were working entirely on the probable available supply of educational opportunities. The question of demand for them was entirely unknown and will depend on:

1. What the men now in service will desire after the war. In collaboration with other interested agencies, the American Medical Association, through the Committee on Postwar Medical Services, is obtaining information on this problem. A questionnaire has been prepared in which are included questions pertaining to the postwar educational desire of medical officers. This is being sent first to 3,000 medical officers. Later it will be sent, with the already assured cooperation of the Surgeons General of the Army, Navy and Public Health Service, to all the 55,000 medical officers in these branches of military service. Information obtained in this extensive undertaking, transferred to International Business Machine punch cards, will be indispensable for further intelligent planning by the Council.

The Committee on Postwar Medical Services has requested the Council to continue its study of supply of postwar educational facilities in the light of results obtained concerning the demand for them as revealed by the questionnaires.

2. The rate of demobilization of medical officers will bear significantly on our planning for their postwar training. Should 300 medical officers declare in the questionnaires described that they desire a year of training in (for example) orthopedic surgery, how many residencies in that will be required? If the demobilization is rapid, we shall need 300 residencies. If it is staggered over three years, 100 places may suffice. In the latter event our present residencies in this field may be adequate. It is obvious that the Council must plan the available postwar educational resources in the light of information made available by the Surgeons General of the Army, Navy and Public Health Service on the rate of demobilization of medical personnel.

The Procurement and Assignment Service has recently ruled that medical officers returning now may be appointed as house officers by hospitals in excess of the assigned quota for a period of one academic year. This should greatly facilitate the adjustment to civilian practice by returning house officers desiring further hospital training.

HOSPITAL TRAINING OF LATIN AMERICAN PHYSICIANS

The Council is continuing its interest in and assistance to Latin American physicians desiring internship and house officer training in our hospitals. These men will be turning to the United States for advanced training in greater numbers than formerly, and every encouragement should be afforded to qualified men in the interests of improved inter-American relationships. An important step in this direction has been taken by the Procurement and Assignment Service, which has recently ruled that at no time need Latin American physicians be counted in the hospital quotas of house officers. This ruling makes it unnecessary for hospitals to weigh the probable effectiveness of a Latin American physician against that of men trained in our own country, since no quota place is lost by the appointment of a Latin American.

MEDICAL SCHOOLS

Two medical schools which have been on probation have sufficiently improved their educational programs to warrant removal of that probation and restoration to the status of full approval.

A new medical school at Dallas, Texas, has been developed by the Southwestern Medical Foundation. The new school employs the clinical facilities formerly used by Baylor University School of Medicine, mainly at the Parkland and associated hospitals. The basic science departments are housed in temporary structures adjacent to the Parkland hospital on property owned by the foundation. Permanent structures will be erected here after the war.

The facilities, faculty, financial status and educational program of the school were found, after two visits by Council representatives, to meet the minimum essentials for an approved medical school. The school has been added to the approved list.

Aided by advice from the Council, the Bowman Gray School of Medicine has expanded its program to include the full four years of instruction at Winston-Salem, N. C. Formerly this institution was an approved school of basic medical sciences, located at Wake Forest, N. C. After thorough investigation, Bowman Gray has been transferred to the Council's list of approved medical schools. The first class graduated in December 1943. The addition of these schools brings the Council's list to a total of 68 approved four year schools of medicine in the United States.

The University of Utah formerly operated an approved school of the basic medical sciences. It has developed a full four year program and will graduate its first class in August 1944. The Council has given aid and advice and made recommendations to the school. Assisted by these the school gives every promise of developing at least a satisfactory program.

The Council is also consulting with the University of Alabama and the University of Missouri concerning expansion from the two year to the four year status. Alabama has selected Birmingham as the site of the school and has appropriated funds for this purpose. The plans at Missouri are in the early formative stage and are even less definite in Mississippi, which is also contemplating a similar development.

The following medical schools were visited during the year by the Council for consultation and inspection services:

University of Alabama School of Medicine.
University of Arkansas School of Medicine (twice).
Emory University School of Medicine.
Bowman Gray School of Medicine.
Hahnemann Medical College and Hospital of Philadelphia.
Baylor University College of Medicine (twice).
Southwestern Medical College of the Southwestern Medical Foundation (twice).
University of Texas College of Medicine.
University of Utah School of Medicine (twice).
University of Vermont College of Medicine.

An inspection was also made of Oglethorpe University School of Medicine, which was not approved. In February 1944 this school withdrew from the field of medical education and discontinued all classes.

It appears that graduates of Middlesex University School of Medicine, which is not included on the Council's approved list, may no longer be eligible for licensure examinations in Massachusetts, which has been the only state in which these graduates have been able to practice.

The Council has received word that the Kansas City University of Physicians and Surgeons of Kansas City, Mo., another unapproved school, will discontinue medical classes in July 1944.

COLLABORATION WITH OTHER AGENCIES

The Council continues to collaborate closely with several agencies, including (1) The Association of American Medical Colleges in all matters pertaining to medical schools, (2) the

various American Specialty Boards in matters relating to the approval of residencies, (3) the Advisory Board for Medical Specialties, with which the Council held a joint meeting in February 1944, (4) the American Council on Education in problems associated with legislation providing postwar education for veterans and plans for college accreditation of academic work done by soldiers and sailors in various military educational programs, (5) the American College of Surgeons in its War Sessions and hospital program, (6) the American Hospital Association in connection with improving hospital standards, (7) the Committee on Postwar Medical Service in connection with postwar educational opportunities for returning medical officers, (8) the Baruch Committee on Physical Medicine, which the Council has aided in some of its extensive studies, (9) the Joint Orthopedic Nursing Advisory Service concerning the supply of public health nurses who have been trained in physical therapy and orthopedic nursing, and (10) the National League of Nursing Education regarding educational standards.

Government agencies with which there have been frequent conferences and close cooperation have included the offices of the Surgeons General of the Army and Navy and Public Health Service, the Army Specialized Training and Navy V-12 officials, the Coordinator of Inter American Affairs, and the Procurement and Assignment Service.

ESSENTIALS OF AN ACCEPTABLE MEDICAL SCHOOL

In the Essentials of an Acceptable Medical School the subdivision of student time in the various departments and subjects is rigidly specified. Such precise specifications are thought to be insufficiently flexible to encourage desirable interdepartmental collaboration in the presentation of related material or the addition of new subjects to the curriculum. The recommendations of the Council for changes in the wording of the Essentials will be presented to the House of Delegates in a supplementary report.

INSPECTIONS OF HOSPITALS, TECHNICAL SCHOOLS AND SPAS, 1943

Following are summarized the inspections of hospitals and technical schools made by the Council during the year 1943:

HOSPITALS

Intern training	54
Residency and fellowships	53
Intern training and residencies	24
Registration	26
Total	157
Individual residencies and fellowships investigated	140

TECHNICAL SCHOOLS

Clinical laboratory schools	28
Physical therapy schools	7
Occupational therapy schools	6
X-ray schools	6
Total	47
Medical Record Librarian schools	2
Spas and health resorts	3
Total number of days in the field	205

CENSUS OF HOSPITALS

The twenty-third annual census of hospitals covering the year 1943 was published in the Hospital Number of THE JOURNAL, March 25. This report of the Council included 6,655 registered hospitals, a net increase of 310 over the previous year. The number of patients admitted in 1943 set an all time record of 15,374,698 as compared with 12,545,610 in 1942. In addition there were 1,924,591 hospital births, an increase of 253,992 over the previous twelve months period. Similarly the daily patient load, or average census, increased by 131,096, not counting newborn infants. Equally significant is the expansion of hospital beds from 1,383,827 in 1942 to 1,649,254 in 1943. This increase of 265,427 beds, incident to wartime needs, is the equivalent of a new 727 bed hospital for each day of the year.

The greatest gain occurred in the federal hospitals, which now have 476,673 beds, or 255,735 more than in 1942. Their admissions increased by 2,356,885, whereas a decrease of 103,733 occurred in the state, county and city hospitals. The nongovernmental group, however, comprising the church related institutions, other nonprofit associations and the proprietary hospitals, showed a substantial increase of 575,936. The general hospitals, with 51 per cent of the total bed capacity, had 14,454,638 admissions, or 94 per cent of all patients admitted in 1943. Their participation in the recent expansion of hospital service can be measured by an increase of 2,820,350 admissions during the year.

A new feature introduced was a study of hospital facilities for contagious diseases. This shows that 1,649 hospitals provide 39,282 beds for this purpose, exclusive of 8,313 beds available in 55 isolation hospitals.

Reports were also included regarding internships and residencies, schools of nursing education and administrative, nursing and technical personnel in hospitals. On Jan. 1, 1944 there were 715 civilian hospitals approved for intern training and 659 for residencies. These include 320 hospitals which are accredited in both classifications. A total of 1,411 schools of nursing are listed with an enrolment of 110,222 student nurses, as compared with 98,166 in 1942.

APPROVED HOSPITALS, APRIL 1, 1944

Following is a summary of hospitals registered and hospitals approved for internships, residencies and fellowships:

Hospital Register

Hospitals registered, April 1, 1943	6,345
Registered during the year	456
Closed or transferred to unclassified file	146
Hospitals registered, April 1, 1944	6,655

Approved Internships

Hospitals approved, April 1, 1943	743
Approved during year	48
Removed from approved list	9
Hospitals approved, April 1, 1944	782

Approved Residencies and Fellowships

Hospitals approved, April 1, 1943	666
Approved during year	85
Removed from approved list	11
Hospitals approved, April 1, 1944	740

APPROVED TECHNICAL SCHOOLS, APRIL 1, 1944

The status of technical schools approved by the Council is as follows:

Schools for Clinical Laboratory Technicians

Approved schools, April 1, 1943	227
Approved during year	18
Removed from approved list	2
Approved schools, April 1, 1944	243

Schools for Physical Therapy Technicians

Approved schools, April 1, 1943	22
Approved during year	7
Removed from approved list	1
Approved schools, April 1, 1944	28

Schools of Occupational Therapy

Approved schools, April 1, 1943	7
Approved during year	6
Removed from approved list	0
Approved schools, April 1, 1944	13

Medical Record Librarian Schools

Approved schools on initial list, June 6, 1943	9
Approved since June 6, 1943	1
Approved schools, April 1, 1944	10

ESSENTIALS OF AN ACCEPTABLE SCHOOL FOR X-RAY TECHNICIANS

On instructions from the House of Delegates at the June 1943 meeting, the Council is collaborating with the American Registry of X-Ray Technicians, the American College of Radiology and the American Society of X-Ray Technicians in the formulation of the Essentials of an Acceptable School for X-Ray Technicians. These essentials will be presented to the House of Delegates in a supplementary report.

EDUCATIONAL STANDARDS IN OPTOMETRY

The Committee on the Conservation of Vision, established by the Board of Trustees as directed by the House of Delegates, has requested the Council "to undertake an investigation of the educational standards of optometry (preferably in cooperation with the Council on Education of the American Optometric Association) for the purpose of raising the standards. . . ." The Council refers this request to the House of Delegates for instructions.

GRADUATE CONTINUATION COURSES

Graduate opportunities for continuation courses for practicing physicians offered in semiannual periods were published in THE JOURNAL of July 3 and Dec. 18, 1943.

COUNCIL PUBLICATIONS

Major publications during 1943 and thus far in the present year include:

Hospital Service in the United States.
State Board Number of THE JOURNAL.
Medical Education in the United States and Canada.
Compilation of Papers Read at the Annual Congress on Medical Education and Licensure.
Choice of a Medical School.
Postwar Graduate Medical Education.
Plan for the Allocation of Interns and Residents in Hospitals.
Approved Colleges of Arts and Sciences.
Schools for Clinical Laboratory Technicians.
Schools for Physical Therapy Technicians.
Schools of Occupational Therapy.
Schools for Medical Record Librarians.

IN APPRECIATION

The Council has met with government and military officials a number of times during the year and wishes to express its appreciation for their recognition of the importance of maintaining adequate educational standards in these difficult times and also for their readiness in supplying data for the Educational Number of THE JOURNAL and for their personal presentations at the Annual Congress on Medical Education and Licensure.

The Council is also deeply grateful to the executive officers of medical schools, hospitals and licensing boards and technical schools for their cordial cooperation in supplying the various data needed for the annual compilation of statistics and for maintenance of the records.

Finally, the Council desires to express its appreciation to the officers and trustees of the American Medical Association for their whole hearted cooperation and assistance in the conduct of the various activities of the past year.

Respectfully submitted.

RAY LYMAN WILBUR, Chairman.
CHARLES GORDON HEYD.
H. G. WEISKOTTEN.
J. H. MUSSER.
HARVEY B. STONE.
REGINALD FITZ.
RUSSELL L. HADEN.
VICTOR JOHNSON, Secretary.

REPORT OF THE COUNCIL ON SCIENTIFIC ASSEMBLY

To the Members of the House of Delegates of the American Medical Association:

The official scientific program to be presented at the 1944 annual session of the American Medical Association is submitted as a part of the report of the Council on Scientific Assembly. The preparation of this program involved the expenditure of unusual effort on the part of section officers and of the Council, because of the unsettled conditions created by the war emergency.

The Council on Scientific Assembly desires to offer an expression of appreciation and gratitude to the section officers for their sacrifice and effort in the preparation of the program, and to those who are to participate in its presentation, most of whom have been overburdened because of the very heavy demands made on them as on practically all physicians.

CONTINUANCE OF SERVICE OF SECTION OFFICERS AND DELEGATES

As there was no meeting of the Scientific Assembly of the Association in 1943, the section officers and delegates who were elected in 1942 have continued to serve in their respective capacities.

SESSIONS FOR GENERAL PRACTITIONERS

In 1941 the House of Delegates instructed the Council on Scientific Assembly to arrange meetings for general practitioners at the next annual session. Two Sessions on General Practice in the Section on Miscellaneous Topics were held at the Atlantic City session in 1942, and a similar arrangement has been made for the presentation of a program for general practitioners at the 1944 session.

MEETINGS OF THE COUNCIL AND CONFERENCE OF SECTION SECRETARIES

The usual meetings of the Council have been held during the year covered by this report, and the annual Conference of Section Secretaries with the Council was held in Chicago on Dec. 1, 1943.

The Council has given official attention to such matters as have been presented and will hold official meetings that may be necessary during the Chicago session, and it is possible that a supplementary report will be submitted to the House of Delegates.

Respectfully submitted.

A. A. WALKER, Chairman.
J. GURNEY TAYLOR.
FREDERICK A. COLLER.
CLYDE L. CUMMER.
EDWARD L. BORTZ.
HERMAN L. KRETSCHMER, President-Elect. } Ex officio.
MORRIS FISHBEIN, Editor, THE JOURNAL. } Ex officio.
OLIN WEST, Secretary. } Ex officio.

REPORT OF THE COUNCIL ON MEDICAL SERVICE AND PUBLIC RELATIONS

To the members of the House of Delegates of the American Medical Association:

The Council on Medical Service and Public Relations, the newest of the Councils of the American Medical Association, was created by the House of Delegates in June 1943. The day after the House acted, the Board of Trustees appointed the following members:

Dr. Louis H. Bauer, Hempstead, N. Y.
Dr. Alfred W. Adson, Rochester, Minn.
Dr. John H. Fitzgibbon, Portland, Ore.
Dr. W. S. Leathers, Nashville, Tenn.
Dr. E. J. McCormick, Toledo, Ohio.
Dr. James R. McVay, Kansas City, Mo.

Dr. James E. Paullin, President of the Association, Brig. Gen. Fred W. Rankin, Past President, and Dr. Olin West, Secretary, were specified as members in the By-Laws setting up the Council. Dr. Roger I. Lee, Chairman of the Board of Trustees, was designated by the Board as its representative.

The Council met first on July 21, 1943 at Chicago and proceeded to organize. Dr. Bauer was elected Chairman, and Mr. J. W. Holloway Jr., Director of the Bureau of Legal Medicine and Legislation, was appointed acting Secretary of the Council. Committees were appointed to draw up a program and a budget and to select a permanent Secretary. Considerable time was spent in discussing the scope of work of the Council and numerous matters were given lengthy discussion.

The second meeting was held at Chicago on Sept. 9 and 10, 1943. A statement of general policies was adopted and referred to the Board of Trustees for approval. These policies are as follows:

1. The Council on Medical Service and Public Relations recognizes the desirability of widespread distribution of the benefits of medical science; it encourages evolution in the methods of administering medical care, subject to the basic principles necessary to the maintenance of scientific standards and the quality of the service rendered.

It is not in the public interest that the removal of economic barriers to medical science should be utilized as a subterfuge to overturn the whole order of medical practice. Removal of economic barriers should be an object in itself.

It is in the public interest that the standards of medical education be constantly raised, that medical research be constantly increased and that graduate and postgraduate medical education be energetically developed. Curative medicine, preventive medicine, public health medicine, research medicine and medical education, all are indispensable factors in promoting the health, comfort and happiness of the nation.

2. The Council through its executive committee and secretary shall analyze proposed legislation affecting medical service. Its officers are instructed to provide advice to the various state medical organizations as well as to legislative committees

concerning the effects of the proposed legislation. It shall likewise be the duty of its officers to offer constructive suggestions to bureaus and legislative committees on the subject of medical service.

3. The Council approves the principle of voluntary hospital insurance programs but disapproves the inclusion of medical services in those contracts for the reasons adopted by the House of Delegates at the 1943 meeting.

4. The Council approves voluntary prepayment medical service under the control of the state and county medical societies in accordance with the principles adopted by the House of Delegates in 1934 and later amended. The medical profession has always been very much opposed to compulsory health insurance because (1) it does not reach the unemployed class, (2) it results in a bureaucratic control of medicine and interposes a third party between the physician and the patient, (3) it results in mass medicine which is neither art nor science, (4) it is inordinately expensive, and (5) regulations, red tape and interference render good medical care impossible. Propaganda to the contrary notwithstanding, organized medicine in general, and the American Medical Association in particular, have never opposed group medicine, prepayment or nonprepayment, as such. The American Medical Association and the medical profession as a whole have opposed any scheme which on the face of it renders good medical care impossible. That group medicine has not been opposed as such is evidenced by the fact that there are many groups operating in the United States which have the approval of the medical profession, and members of these groups are and have been officials in the national and state medical organizations. That group medicine is the Utopia for the whole population, however, is not probable. It may be and possibly is the answer for certain communities and certain industrial groups if the medical groups are so organized and operated as to deliver good medical care.

5. The Council believes that many emergency measures now in force should cease following the end of hostilities.

6. The Council believes that the medical profession should attempt to establish the most cordial relationships possible with allied professions.

7. There is no official affiliation between the American Medical Association and the National Physicians Committee. However, since it is the purpose of the National Physicians Committee to enlighten the public concerning contributions which American medicine has made and is making in behalf of the individual and the nation as a whole, it is the opinion of the Council that the medical profession may well support the activities of the National Physicians Committee and other organizations of like aims.

8. American medicine and this Council owe a responsibility to our colleagues who are making personal sacrifices to answer the call of the armed forces. Therefore the Council expresses the desire to cooperate with the medical committee on postwar planning in order to assist our colleagues in reestablishing themselves in the practice of medicine and in the preservation of the American system of medicine.

The Council then considered its purposes and functioning and adopted a plan covering them. This plan was submitted to the Board of Trustees and was finally adopted at the meeting on Nov. 20, 1943. This plan is as follows:

ORGANIZATION

Officers.—The Council shall elect annually:
A chairman.
A vice chairman.
A full time secretary.

An executive committee of three shall be created, which include the Chairman, the Council member of the Board of Trustees and a third member to be chosen annually from the duly appointed or elected members of the Council on Medical Service and Public Relations. This committee shall exercise such functions as are delegated to it by the Council.

The central office of the Council is to be located in the office building of the American Medical Association in Chicago, Illinois.

The functions of the Council outlined in the By-Laws are closely integrated and cannot well be considered separately. To carry them out it is obvious that the Council must have adequate sources of information, maintain close contact with constituent associations and component societies, and establish close relationship with the already existing bureaus and departments of the Association.

The Council, therefore, subject to the approval of the Board of Trustees, has decided on the following methods of operation:

1. In carrying out the directive in the By-Laws as to relationship with the other bureaus and departments of the Association, the Council has established close collaboration (*a*) with the Bureau of Medical Economics, which has been asked and has expressed the willingness to do the research on many of the economic problems necessary for the Council's study, and which is well equipped to carry out such research; (*b*) with the Bureau of Legal Medicine and Legislation; joint bulletins will be issued with that Bureau on legislative matters; attempt will be made to effect wider distribution and, if necessary, more frequent publications of such bulletins; (*c*) with the Bureau of Public Relations. The Council shall utilize the sources of information of this bureau, and joint bulletins may be issued from time to time with it and, if indicated, with other bureaus of the American Medical Association. All planning will be to avoid overlapping of functions and duplication of effort.

2. The Council on Medical Service and Public Relations has extended the sources of information of the American Medical Association on problems with which the Council is specifically concerned. Through its membership and by cooperation with constituent associations and component societies and the utilization of other facilities, the Council will disseminate such information toward effecting its objectives. The Secretary of the Council, with its approval, will undertake such travel as may be necessary.

3. In order that constituent associations and component societies may be kept informed of the activities of the Council and of proposed changes in the status of medical care, and that the Council may be of assistance to those associations and societies, the Council has requested each state association to designate an existing committee or create a new committee to function with the Council on the state level.

Each state organization has also been requested to contact each component society in the state and ask it similarly to designate or form a committee to function in connection with the programs of the Council. Where such organization is feasible, it has been suggested that committees be created along the lines of congressional districts.

Such state and county committees have been urged to keep the Council informed of their local problems and activities.

State organizations also will be requested from time to time to conduct experiments in the various methods of medical care and to inform the Council of their results so that the Council may study and evaluate the experiments and transmit the information acquired to all concerned.

4. The Council feels that under its directive it is its duty to endeavor to evolve such modifications of our present system of medical care as may be necessary to cover all the people and be in accord with the traditions of American medicine as to high standards of medical care and the American tradition of free enterprise as already outlined in paragraph 1 of the Council's Policies previously published. To accomplish this, study must be made of all economic, social and similar aspects of such care.

5. In order that the foregoing program may be effectively carried out, the Secretary of the Council, with the guidance of the Council in conformity with the herein expressed relationships with other bureaus and departments, shall inform the profession through the various state organizations of all pending national legislation and bureau directives affecting the practice of medicine. It shall likewise be his duty, with the guidance of the Council, to arrange for medical representation at meetings and hearings pertaining to medical care, collaborating in the representation with other councils and bureaus of the American Medical Association that have an interest in this same subject.

6. The Secretary is instructed with the supervision of the Council, and in collaboration with the Bureau of Public Relations, to disseminate information concerning the activities of

the Council through the publications of the American Medical Association and the various state medical journals, and to prepare and release information on medical care.

In accordance with this plan, Dr. E. J. McCormick was elected Vice Chairman of the Council, and an Executive Committee appointed consisting of the Chairman, the Trustee member, Dr. Lee, and Dr. Adson.

All state societies were circularized and asked to designate committees to work with the Council, and through them the county societies were asked to appoint like committees. Each local committee was asked to establish contacts with local lay organizations. They were requested to study and start a compaign of education on the Wagner-Murray-Dingell bill. Forty-four state societies designated committees. Two replied that they had no such committees, and two were not heard from. Five states sent in the lists of their county committees. Indiana reported at the Secretaries Conference and to the Council on an elaborate contact plan which it set up, and this was forwarded to all state societies for their information with the suggestion that they use such parts of the plan as were suited to their organizations and needs.

The Chairman was instructed to draw up a statement of the attitude of the Council on the Wagner-Murray-Dingell bill. In collaboration with Mr. Holloway, this was done. It was printed in THE JOURNAL, and reprints were forwarded to all state societies and editors of all state journals. Further requests for copies followed, and the statement had a wide distribution.

It was felt that the sources of information of the Association at Washington should be extended, and this was done.

At the November meeting it was decided to issue a semi-monthly Bulletin of information received, and this went into effect in January 1944. The Bulletin is sent to the members of the House of Delegates, all state secretaries, editors of state journals, state committees and county committees collaborating with the Council and to all others requesting it. At present the mailing list comprises approximately 2,000 names, and it is still growing. It is felt that these Bulletins are most useful to those actually engaged in the work of organized medicine.

The Bureau of Medical Economics prepared a survey of health insurance in all English speaking countries, and at the Council's request it brought up to date its 1940 Survey of Medical Service Plans.

A "Question and Answer Booklet on Sickness Insurance and the Wagner-Murray-Dingell Bill" was prepared jointly by the Council and the Bureau of Medical Economics, and it will be ready shortly for distribution. It is intended to have this available to all doctors for their personal information and, if they desire it, for their patients.

The attitude of the Council on compulsory sickness insurance is stated earlier in this report, and its attitude on the Wagner-Murray-Dingell bill is given in its statement on that bill. It is recommended that the House adopt these statements as its policy on the subjects involved.

Just prior to the November meeting the Council was able to obtain the services of Dr. G. Lombard Kelly, dean of the University of Georgia School of Medicine, as a full time secretary. Dr. Kelly is on leave of absence from the medical school until July 1. Dr. Kelly attended the November meeting and took over his post as Secretary on Jan. 1, 1944.

The Council owes a debt of gratitude to Mr. J. W. Holloway Jr., who acted as Secretary for six months. Mr. Holloway, Director of the Bureau of Legal Medicine and Legislation, was unusually busy with that Bureau, owing to one of his assistants being in the service, and yet he devoted a great deal of time and effort to the work of the Council.

The Council met again on Feb. 14 and 15, 1944 and at that time decided that it was advisable to open an office in Washington. Consequently the Board of Trustees was asked to appropriate funds for establishing in Washington, under the auspices of the Council, an office of medical economic research, this office to be charged with the collection of information and statistical data concerning medical care, its distribution, its availability, its costs and its control in various portions of the United States and that the information thus collected be made available to the medical profession through the publications of the American Medical Association, to the Bureau of Medical Economics of the American Medical Association for its studies of this problem, and to other appropriate agencies interested in the extension of medical service and the provision of medical care and related subjects. The Board approved making a survey of the situation.

At the same meeting a conference was held with representatives of the National Conference on Medical Service.

Another conference was held with Dr. Martha Eliot of the Children's Bureau on the subject of the E. M. I. C. A verbatim report of this conference will have appeared in THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION prior to the publication of this report.

Considerable study has been given to the subject of voluntary insurance, diagnostic clinics and medical service bureaus. The Council hopes to cover some of these subjects in a supplementary report.

The Council studied the status of medical students and feels that they should be brought into the fold of organized medicine as early as possible so that they may be inculcated with the ideals and ethics of medicine. Hence it recommends that the House direct the Board of Trustees to work out a plan whereby students in approved medical schools can become Student Members of the Association, and that the Board prepare the necessary changes in the Constitution and By-Laws, for submission to the House, in order to accomplish this.

The Council also has requested the Council on Medical Education and Hospitals to consider taking the necessary steps as soon as practicable to have each medical school give a course on medical sociology, medical economics and medical ethics.

It was decided that an official meeting of the Council be held in Washington in May and to devote one day of its meeting to a conference with invited representatives of other agencies concerned with medical care. A supplementary report will be made on this.

A budget was adopted at the February meeting and approved by the Board of Trustees.

Still other matters are under consideration by the Council, and it is hoped that a supplementary report can be made on at least some of them.

There has been close collaboration with the Bureau of Legal Medicine and Legislation on legislative matters besides the Wagner-Murray-Dingell bill, and that Bureau has issued legislative bulletins, in addition to the Bulletins of the Council.

The Council has had the complete cooperation of the Bureau of Medical Economics. That Bureau, like others, is at present understaffed but as soon as possible will be in a position to undertake more extensive surveys.

There is also close cooperation with the Bureau of Public Relations, and all sources of information are used jointly. It is planned to publish more frequent statements from the Council in THE JOURNAL.

Members of the Council and the Secretary have spoken frequently before state and county medical societies and lay organizations and have entered into debates and forums on the work of the Council and on the Wagner-Murray-Dingell bill.

One member of the Council was unable to attend its meetings because of urgent military duties, one member missed one meeting because of illness, and one member missed one meeting for another unavoidable reason. Otherwise all meetings of the Council have been fully attended.

A supplementary report will be submitted to the House of Delegates at a later time.

Respectfully submitted,

LOUIS H. BAUER, Chairman.
E. J. MCCORMICK, Vice Chairman.
ALFRED W. ADSON.
JOHN H. FITZGIBBON.
W. S. LEATHERS.
JAMES R. MCVAY.
JAMES E. PAULLIN.
FRED W. RANKIN.
ROGER I. LEE.
OLIN WEST.
G. LOMBARD KELLY, Secretary.

Report of the War Participation Committee

To the Members of the House of Delegates of the American Medical Association:

The War Participation Committee of the American Medical Association originated from the report of the 1941-1942 Committee on Medical Preparedness to the 1942 House of Delegates. The latter committee suggested that it be discontinued and a new committee created for the purpose of keeping in close touch with all war related policies affecting the quality and efficiency of medical service both to the armed forces and to the civilian population.

Paced by Chairman Abell's A. M. A. Committee on Medical Preparedness, the forty-eight constituent state medical associations had served equally well their country's war needs through the instrumentality of similar committees.

The heavy responsibilities of the Procurement and Assignment Service, which in many states succeeded Medical Preparedness, as earlier known, have steadily become more complex, with doubled accent on the accessibility of adequate medical service to war industries, to thinly populated districts, to essential institutions and most recently on sufficient physicians to serve plans for a more rapidly expanding Army and Navy.

Since our committee's report to the 1943 House of Delegates two meetings have been held, one in July, the other in October, both in Washington, D. C., in order that we might confer on the second day with the Directing Board of Procurement and Assignment Service. The latter were definitely interested on both occasions in receiving advice and promise of cooperation in the pressing problem of meeting the omnipresent military and civilian service needs for doctors of medicine. In October we also met in joint session with Director Paul V. McNutt of the War Manpower Commission, representatives of the various Surgeons General, and of the national dental and nursing organizations. At this meeting considerable discussion was devoted to the obtaining of definite statements as to the stated needs of the armed forces for additional professional personnel as well as justification of the current use of such personnel in the armed forces.

The chairman of your War Participation Committee in November presented the functions of the committee as a coordinating agency before those in attendance on the annual conference of state medical association secretaries and editors held at A. M. A. headquarters in Chicago. At that time a request was again made for the creation of war participation committees by the various state medical associations rather than to continue the duties of such committees among the responsibilities of preexisting committees on medical preparedness or already harassed state committees on the Procurement and Assignment Service.

It is with regret that we report that up to the present time—two years after the creation of the original war participation committee—only twenty state associations have reported committees under such title. Nevertheless, our committee still holds the view that the personnel of various state association committees that have served for three years as members of a committee on Medical Preparedness or of a committee on Procurement and Assignment Service are quite likely to have their conception of their functions well consolidated and crystallized and not to respond too enthusiastically when the A. M. A. Committee on War Participation writes, asking for their cooperation throughout their respective states in such less pressing movements as (1) maintenance of war records of physicians in military service, (2) preservation of the local economic and professional interests of absent members and (3) preparing now to implement promptly at the conclusion of the war the plans currently being laid by the Committee on Postwar Medical Service of the American Medical Association and related organizations.

Such problems as these exist and will continue to develop in every state in the Union and may readily prove of equal importance to more academic discussions and planning, such as prompt cancellation of emergency measures that have involved (*a*) medical practice, (*b*) medical licensure and (*c*) medical education during the war period.

SHALL WE PERMIT THE PUBLIC TO FORGET?

We recently brought to the attention of each state association's war participation committee its responsibility to the membership absent in military service involved in keeping before the people of the state the fact that practically all physicians now in military service entered on a voluntary basis. It is undoubtedly true of some states—because of publicized emphasis on the difficulty in obtaining a desired quota of physicians for the more recent rapidly expanding military forces—that the public may have completely lost sight of the priceless voluntary feature of the military medical service rendered by 50,000 American physicians. It has been said that even line officers in military service are definitely under the impression that there is a special kind of "draft" for medical officers. The mere fact that the Procurement and Assignment Service has in the past twenty months been so directly connected with the War Manpower Commission may have helped to cause the average person to overlook the fact that the Procurement and Assignment Service has been and remains purely an advisory function. To give point and emphasis to this paragraph, we quote from a very earnest communication recently addressed to the chairman of the American Medical Association Committee on War Participation, which has made a deep impression on several:

"Now why should we [physicians] in the armed services be interested in having the people know that we are, in effect, volunteers and not draftees? Our story is not being told to the people. Perhaps before the end of the war the medical profession will have its whole future decided for it by political action by the people. This is as it should be—provided very definitely that the people have accurate impressions to guide them in their decisions. The minds of the people who shall have to decide about us one of these days will be conditioned to the truth about our war service. An enormous responsibility rests on the members of the American Medical Association to see to it that the people are told the story of what our contributions have been to this war. . . . Let us look to our security in the hearts of the people, never losing sight of the danger from demagoguery and clever publicity campaigns."

Our committee during the past year has on more occasions than one brought to the attention of each constituent state medical association the wartime problems involved in medical practice, medical licensure and medical education and the inherent organizational responsibilities connected with maintenance of war records and preservation of economic and professional interests of absent members. We have also brought to attention outstanding endeavors by the War Participation Committee in certain states to lighten the labors of the Procurement and Assignment Service and to anticipate community health needs likely to be related to prolongation of the hoped for shorter duration of the war.

We feel, therefore, that we have little additional to recommend to the membership of the Association through its House of Delegates than to stress the individual member's responsibilities to his fellow practitioners absent in military service and to remind each that he can best perform this home front responsibility by spreading truth regarding the wisest means of distributing medical service more widely while at the same time rendering the professional service that will best protect the health interests of all the people. Only by such means may we each help to develop the essential local reservoirs of public good will that the proposals of the politically minded will never succeed in draining off.

Respectfully submitted,

WALTER F. DONALDSON, Chairman.
EDWARD R. CUNNIFFE.
CLYDE L. CUMMER.
JOHN H. O'SHEA.
WILLIAM R. MOLONY SR.
JAMES E. PAULLIN.
HERMAN L. KRETSCHMER.
ROGER I. LEE.
MORRIS FISHBEIN.
OLIN WEST.

} Ex officio.

Medical News

(PHYSICIANS WILL CONFER A FAVOR BY SENDING FOR THIS DEPARTMENT ITEMS OF NEWS OF MORE OR LESS GENERAL INTEREST: SUCH AS RELATE TO SOCIETY ACTIVITIES, NEW HOSPITALS, EDUCATION AND PUBLIC HEALTH.)

CALIFORNIA

Change in Health Officers.—Dr. Charles R. Blake, on account of ill health, has resigned as health officer of Richmond, a position he held since 1910; the resignation was effective April 1, the thirty-fourth anniversary of his appointment, newspapers reported.

Contest in Surgical Essays.—The San Francisco Surgical Society announces that its annual contest in the field of general surgery, open to young physicians in San Francisco and vicinity, again carries first and second prizes of $150 and $100, respectively. The contest was inaugurated last year, the competing essays to represent original work in the field of experimental or clinical surgery, but not necessarily based on an original idea. The closing date this year will be June 30. Additional information may be obtained from Dr. John W. Cline, secretary of the society, 490 Post Street, San Francisco 2.

Graduate Medical Education.—The San Francisco County Medical Society devoted its meeting April 12 to a symposium on graduate medical education. The following participated:

Dr. Arthur L. Bloomfield, San Francisco, Graduate Training for Returning Medical Officers.
Dr. Benjamin W. Black, superintendent of the Highland-Alameda County Hospital, Oakland, The Role of the Public Hospital in Graduate Medical Education.
Capt. Arthur B. Dearing (MC), and Lieut. Col. Russell H. Patterson, M. C., What Will the Returning Medical Officer Need?
Dr. Howard C. Naffziger, San Francisco, Future Needs in Graduate Medical Training.
Dr. Loren R. Chandler, San Francisco, Methods of Providing Graduate Training in Medicine.

State Medical Meeting.—The California Medical Association will hold its annual meeting in Los Angeles, May 7-8, under the presidency of Dr. Karl L. Schaupp, San Francisco. One general meeting will be devoted to a symposium on amputations, in which the speakers will be Capt. John P. Owen (MC), Capt. Joseph M. Greer (MC), Lieut. Comdr. Gerald B. O'Connor (MC), Capt. Henry H. Kessler (MC) and Comdr. Douglas D. Toffelmier (MC). Among other speakers on the general program will be:

Dr. Alice Hamilton, Washington, D. C., New Problems in the Field of the Industrial Toxicologist.
Brig. Gen. Charles R. Glenn, M. C., Aviation Medicine, A Specialty in War and Peace.
Dr. Phil W. Shumaker, Beverly Hills, Angioneurotic Edema of Larynx.
Drs. Hildegarde R. J. Wilkinson and Charles M. Malone, Los Angeles, Single Caudal Block in Obstetrics for Analgesia and Delivery.
Drs. Samuel M. Martins and Jennie M. Howell, Los Angeles, The Antepartum Use of the Sulfonamides.
Dr. Herbert F. Traut, San Francisco, Exfoliation of Cells in Uterine Cancer: Its Importance in Diagnosis.
Dr. Thomas B. Dunn, Oakland, Practical Aspects of Tropical Medicine in America.
Comdr. Benjamin E. Konwaler (MC), Carbon Tetrachloride Poisoning.

The woman's auxiliary to the state medical association will also hold its convention in Los Angeles.

ILLINOIS

Dr. Black Donates Collection to State Society.—Dr. Carl E. Black, Jacksonville, who has been collecting photographs of physicians for a number of years, plans to present his collection to the Illinois State Medical Society to be placed in the care of the Illinois State Historical Society, Springfield. The collection will be given space in the centennial building, where the photographs will be easily accessible. The collection contains more than 3,000 photographs, of which more than 1,300 are of Illinois physicians. About 300 photographs are those of members of the "Fifty Year Club" of the state medical society. Dr. Black will have an exhibit of the "fifty year men" pictures at the Illinois State Medical Society meeting at the Palmer House, Chicago, May 17. Dr. Andy Hall, Mount Vernon, former director of the Illinois State Department of Public Health, recently gave 11 photographs of physicians in the Hall family to Dr. Black.

Chicago

Promotions at Northwestern.—Recent promotions on the faculty of Northwestern University Medical School include those of Dr. Henry R. Jacobs to assistant professor of medicine, Dr. Irving Puntenney to assistant professor of ophthalmology and Dr. Frederick R. Schmidt to assistant professor of dermatology.

Lecture Named for Richard Jaffé.—The first Richard H. Jaffé Lecture of the Institute of Medicine of Chicago, established recently under a fund in memory of Dr. Jaffé, pathologist at Cook County Hospital who died Dec. 17, 1937, will be delivered at the Palmer House, June 23, by Dr. William F. Petersen on "Organic Variability and Heart Disease."

Meeting on Nutrition.—The Chicago Nutrition Committee and a group of cooperating agencies devoted a meeting, April 11, to the theme "Improving Nutrition in Wartime Chicago." Among the speakers were:

Conrad A. Elvehjem, Ph.D., Madison, Wis., Nutrition—A Major Factor in Human Health.
Dr. Morris Fishbein, Editor, THE JOURNAL, Fads and Fallacies in Popular Nutrition Information.
Wilburn L. Wilson, War Food Administration, Washington, D. C., What Is Our Nutrition Goal?
Marjorie M. Heseltine, Children's Bureau, U. S. Department of Labor, What Can Health and Welfare Agencies Do to Improve Nutrition in Chicago?

At an evening session the speakers were Paul H. Appleby, Washington, D. C., undersecretary, U. S. Department of Agriculture, on "Feeding the World" and Dr. Edward J. Bigwood, Brussels, Belgium, "Food Problems in a Conquered Country."

MARYLAND

Borden Award Goes to Dr. McCollum.—Elmer V. McCollum, Ph.D., professor of biochemistry, School of Hygiene and Public Health, Johns Hopkins University, Baltimore, since 1917, has been announced as the first recipient of the Borden Award given by the American Institute of Nutrition. The 1944 prize was given to Dr. McCollum "for his long years of pioneering research in nutrition. His contribution to our knowledge of the vitamin content of milk and of the high nutritive value of 'protective foods,' one of which is milk, have served as foundation stones for improving through foods the nutrition and health of the human race," it was reported (THE JOURNAL, Nov. 13, 1943, p. 715).

MISSISSIPPI

State Medical Meeting in Jackson.—The seventy-seventh annual session of the Mississippi State Medical Association will be held at the Robert E. Lee Hotel, Jackson, May 9-10, under the presidency of Dr. Ellis LeRoy Wilkins, Clarksdale. Among the out of state speakers will be:

Dr. Walter E. Wilkins, U. S. Public Health Service, Public Health Nutrition Problems.
Dr. Alonzo E. Hardison, Atlanta, Ga., Public Health Activities of American Red Cross in Mississippi.
Dr. W. Likely Simpson, Memphis, Tenn., Cancer of the Larynx.
Dr. Robert L. Sanders, Memphis, Subtotal Gastrectomy for Benign Lesions of the Stomach and Duodenum: Indications and Results.
Dr. Alton Ochsner, New Orleaus, Incidence and Early Diagnosis of Carcinoma of the Lung.

The woman's auxiliary to the state association will meet at the Robert E. Lee Hotel, May 9-10, and the Mississippi State Hospital Association at the Heidelberg Hotel, May 8. Dr. John Darrington, Yazoo City, will deliver the Ewing Fox Howard Oration before the state medical association Tuesday evening on "Why the Medical Profession is a Great Profession."

NEW YORK

State Medical Meeting.—The Medical Society of the State of New York will convene in annual session at the Hotel Pennsylvania, New York, May 8-11, under the presidency of Dr. Thomas A. McGoldrick, Brooklyn. Out of state speakers will include:

Dr. Donald G. Anderson, Boston, Clinical Experience with Penicillin.
Dr. Lewis M. Hurxthal, Boston, Practical Management of Certain Endocrine Disorders.
Dr. James L. Poppen, Boston, Surgical Treatment of Hypertension.
Dr. Frank H. Lahey, Boston, Surgery of the Stomach and Duodenum.
Dr. Everett D. Kiefer, Boston, Diagnosis of Disorders of the Small and Large Intestine.
Dr. Robert A. Hingson Jr., Philadelphia, Continuous Caudal Analgesia.
Major Stevens J. Martin, M. C., Regional Anesthesia in the Army.
Dr. Sara M. Jordan, Boston, Medical Aspects of Recalcitrant and Complicated Ulcer.
Capt. Joseph E. Hamilton, M. C., War Wounds of the Colon and Rectum.
Drs. Eli Jefferson Browder, Brooklyn, and Robert Watson, Little Rock, Ark., Lesions of the Cervical Intervertebral Disk: Clinicopathologic Study of Twenty-Two Cases.
Dr. Lyman Burnham, Englewood, N. J., Vitamin C in Erythroblastosis Fetalis—Its Possible Role in Etiology and Prevention.
Major Charles E. Galloway, M. C., Diagnosis and Treatment of Lesions of the Uterine Cervix.
Dr. Virgil S. Counseller, Rochester, Minn., Vesicovaginal Fistula.
Capt. Rufus H. Alldredge, M. C., The Management of War Amputations in a General Hospital.
Dr. Harrison S. Martland, Newark, N. J., Medicolegal Systems—Actual and Ideal.
Dr. Hyman Green, Boston, Practical Experience with Congenital Heart Disease.
Dr. Arnold L. Gesell, New Haven, Conn., The Role of Development Diagnosis in Clinical Medicine.
Dr. Nathaniel Jones, Jacksonville, Fla., The Treatment of Early Syphilis with Fever and Mapharsen.

Mac F. Cahal, Dallas, Texas, The Role of the Hospital in Medical Care
Dr. Irvine H. Page, Indianapolis, Recent Advances in Etiology, Diagnosis and Treatment of Essential Hypertension.
Dr. Reginald H. Smithwick, Boston, Experience with the Surgical Treatment of Hypertension.
Dr. Samuel C. Harvey, New Haven, Conn., The Treatment of Infection with Particular Reference to the Peritoneum.
Dr. Henry R. O'Brien, Charlottesville, Va., History of Public Health in Cattaraugus, Chautauqua and Allegany Counties.
Dr. David M. Davis, Philadelphia, Intubated Ureterotomy.
Dr. Edward L. Compere, Chicago, The Poliomyelitis Epidemic in Chicago in 1943.

Dr. Edward L. Howes, associate clinical professor of surgery, New York Post-Graduate Medical School and Hospital, Columbia University, New York, will present the sixth lecture under the A. Walter Suiter Lectureship, entitled "Recent Advances in Studying the Problems of Wound Healing and Their Effect on Treatment." Other groups meeting at this time include the woman's auxiliary to the state society, the New York State Association of School Physicians and the Women's Medical Society of New York State. A feature of the scientific exhibits this year will be a comprehensive exhibit on glaucoma, sponsored by the committee on glaucoma of the National Society for the Prevention of Blindness in cooperation with a number of ophthalmologists.

New York City

The Bela Schick Lecture.—Major Albert B. Sabin, M. C., associate professor of pediatrics, University of Cincinnati College of Medicine, will deliver the Bela Schick Lecture of Mount Sinai Hospital, May 2. His address will be on "Studies on the Natural History of Poliomyelitis."

Physician Named as First Chinese to Be Naturalized Since Repeal of Exclusion Act.—The first civilian Chinese to be naturalized in New York City since the Chinese exclusion acts were repealed last December renounced his British citizenship on April 11 and was sworn in as an American. The physician's name is Dr. Rupert C. Sancho and his speedy naturalization was possible, according to the New York *Times*, because he had made formal declaration in 1930 of his intention to obtain U. S. citizenship. The physician was permitted at that time to file his declaration in order to comply with New York State laws governing the practice of medicine. He had graduated at Howard University College of Medicine, Washington, D. C., in 1929 and began the practice of medicine in New York in 1930. He was born in Port of Spain, Trinidad.

Expansion in Tropical Medicine Continues.—The program on tropical medicine at Columbia University College of Physicians and Surgeons now includes a special eight weeks course offering a full time program in the various aspects of tropical medicine, attended by medical officers of the U. S. Navy as well as graduate students in public health. This phase is under the direction of the DeLamar Institute of Public Health, which is also assisting in expanding the teaching of parasitology and tropical medicine to the medical students. New additions to the faculty of the institute include Kathleen Hussey, Ph.D., and Gertrude Spremulli, Ph.D., both research associates in parasitology. Dr. Harold W. Brown is the first professor of parasitology in the new department of tropical medicine (THE JOURNAL, Nov. 6, 1943, p. 647), which was recently inaugurated at the school. Courses which recently have been made a part of the regular curriculum are on malariology, helminthology, protozoology, medical entomology, nutrition in relation to the tropics, tropical sanitation and hygiene, epidemiology, public health practice and specific problems of health and disease in the tropics.

NORTH DAKOTA

Personal.—Dr. Robert G. White, formerly of Valley City and Bismarck, has been named director of the Burke-Minot-Ward district public health unit with offices at Minot, succeeding the late Dr. Olaf O. Haraldson, Minot.

State Medical Meeting in Fargo.—The fifty-seventh annual meeting of the North Dakota State Medical Association will be held at the Elks Club, Fargo, May 7-9, under the presidency of Dr. Frank I. Darrow, Fargo. The house of delegates session will be held at Gardner Hotel. Among the speakers on the program will be:

Dr. William W. Bauer, Director, Bureau of Health Education, American Medical Association, Doctor Means Teacher.
Dr. Charles M. McLane, New York, Sterility.
Dr. Edward H. Skinner, Kansas City, Mo., Navigating the Medical Future.
Dr. Henry F. Helmholz, Rochester, Minn., Urinary Tract Infections in Childhood.
Dr. Lawrence R. Boies, Minneapolis, The Symptom of Headache.
Dr. Henry E. Michelson, Minneapolis, Common Disorders of the Skin.
Dr. Carl G. Morlock, Rochester, Indications for the Surgical Treatment of Peptic Ulcer.

Other groups meeting will include the North Dakota Health Officers' Association, North Dakota Academy of Ophthalmology and Otolaryngology, North Dakota Society of Obstetrics and Gynecology and North Dakota Radiological Society.

Public Health Program in Fargo.—On May 18 a group of representatives of the American Public Health Association will lecture at the Hotel Gardner, Fargo, presenting the following program:

Ellis S. Tisdale, sanitary engineer, U. S. Public Health Service, Looking Ahead in Public Health Engineering.
William Ford Higby, San Francisco, Voluntary Agencies and the Promotion of County Health Departments.
Dr. Charles E. Lyght, New York, Guiding Principles in a Health Education Program, the Fundamentals of Health Education and How to Make Them Practical.
Dr. Martha G. W. MacDonald, Washington, D. C., Mental Hygiene in the Child Health Conference.
Dr. Arthur Massey, Coventry, England (subject to be announced).
Dr. Reginald M. Atwater, New York, Highlights of the Changing Scene in Public Health.
Chauncey D. Leake, Ph.D., Galveston, Texas, Disease Control with Chemicals.
Miss Pearl McIver, senior public health nursing consultant, U. S. Public Health Service (subject to be announced).

The speakers will hold group discussions the following day, the program to conclude with a "round-up" with all speakers participating.

PENNSYLVANIA

Symposium on Electroencephalography.—"Principles and Practice of Clinical Electroencephalography" was the theme of a symposium in military medicine on April 26 in Aspinwall. Speakers discussing this phase were Dr. Yale D. Koskoff and S. Gutmacher, R.N., Pittsburgh. Other speakers included:

Major James W. Minteer and Major Otis R. Farley, both in medical corps, Electroencephalogram in Inductees and Appointees.
Major Howard T. Fiedler, M. C., The Electroencephalogram in the Replacement Center.
Major Robert P. Kemble, M. C., The Electroencephalogram in the Military General Hospital.
Major Charles B. Huber, M. C., The Electroencephalogram in the Veterans' Hospital.

Philadelphia

The Samuel Gross Prize.—The Philadelphia Academy of Surgery announces that the Samuel D. Gross Prize of $1,500 will be available this year. Competitive essays must be sent to the academy, care of the Philadelphia College of Physicians, 19 South 22d Street, Philadelphia, on or before Jan. 1, 1945. Bearing out the stipulations of the late Dr. Samuel D. Gross, the prize is awarded "every five years to the writer of the best original essay, not exceeding 150 pages, octavo, in length, illustrative of some subject in surgical pathology or surgical practice founded upon original investigations, the candidates for the prize to be American citizens."

Postgraduate Institute.—The ninth annual postgraduate Institute of the Philadelphia County Medical Society will be held at the Bellevue-Stratford Hotel, May 2-5, on the theme "Modern Diagnosis and Treatment." General topics of discussion will include suppurative diseases of the lungs, rehabilitation, postoperative pulmonary complications, postoperative circulatory complications, low back pain and psychosomatic aspects of gastroenterology. Among the speakers on the program will be:

Dr. Joseph Stokes Jr., Air Disinfection by Glycol Vapors and Ultraviolet Light.
Dr. Ella Roberts, Sulfonamide Prophylaxis in Rheumatic Fever.
Pauline B. Mack, Ph.D., State College, Pa., Nutritional Assessment of School Children.
Dr. Franklin R. Miller, The Leukemias.
Dr. Lowell A. Erf, Blood and Blood Plasma.
Dr. Charles E. Koop, Gelatin as a Plasma Substitute.
Dr. William L. White, Limitation in the Value of Local Sulfonamide Therapy.
Dr. Harold A. Zintel, Maintenance of Nutrition in Surgical Patients.
Dr. William G. Sawitz, Malaria.
Dr. George Morris Piersol, Rehabilitation and Its Relation to Physical Therapy.
Dr. Jonathan E. Rhoads, Demise of Tannic Acid Treatment of Burns.

TEXAS

New Class in Physical Therapy.—On March 27 the University of Texas Medical Branch, Galveston, opened a new class in physical therapy. Only a limited number of students are to be accepted. The facilities for training these students include a therapeutic pool and "whirlpool" for hydrotherapy, exercise equipment, and x-ray and ultraviolet ray equipment. The course calls for 1,315 hours of training. Students are enrolled for six months in anatomy classes together with medical students and study dissection, pathology, physiology, psychobiology and other medical courses. In addition they will study hydrotherapy, massage, electrotherapy and fever therapy, x-rays and the Kenny system.

State Program Held in Four Cities.—The State Medical Association of Texas, because of conditions imposed by the war, has divided its annual program so that one scientific section, public health, was held in Austin at the Driskill Hotel, April 19-20, and three scientific sections, medicine, pediatrics and eye, ear, nose and throat, in Fort Worth, Hotel Texas, April 20-21. The sections on surgery, obstetrics and gynecology, radiology and physical therapy and clinical pathology will meet at the Gunter Hotel, San Antonio, May 3-4, and the house of delegates will meet at the Hotel Adolphus, Dallas, May 10-11. The program lists the following out of state speakers:

Dr. Carl M. Peterson, Secretary, Council on Industrial Health, American Medical Association, Industry Needs the Physician.
Lieut. Col Oza J. LaBarge, M. C., Virus Disease of the Respiratory Tract.
Major John S. Mikell, M. C., The Ear in Flying Personnel.
Major Thomas Brent Wayman, M. C., and Dr. Esther C. Marting, Cincinnati, A New Method of Treatment of Infiltrating Carcinoma of the Bladder.
Dr. Arthur Purdy Stout, New York, Tumors of Blood Vessels.

The annual Health Officers and Health Unit Directors Conference was held in Austin, April 18, and the Texas State Heart Association met in Fort Worth, April 20.

VIRGINIA

Venable Lectureship in Traumatic Surgery Created.—The Charles Scott Venable annual lectureship in traumatic surgery has been established in the University of Virginia Department of Medicine, Charlottesville. The lectureship will be supported by royalties from the sale of an adjustable splint designed by Dr. Charles Scott Venable Jr., San Antonio, Texas, president of the State Medical Association of Texas and also president of the American Association for the Surgery of Trauma. The splint has been made available without royalties or encumbrances to the Red Cross and civilian defense agencies. Dr. Venable's father was professor of mathematics at the University of Virginia from 1866 to 1896.

WYOMING

State Medical Meeting.—The regular annual meeting of the Wyoming State Medical Society will be held at Casper, May 28. No scientific session will be held. The program will include routine business and election of officers for the ensuing year.

HAWAII

Personal.—Stanley D. Porteus, D.Sc., director of the Hawaii Psychological Clinic, Honolulu, has been granted an eight months leave of absence to accept an invitation from Dr. Walter Freeman, professor of neurology, George Washington University School of Medicine, Washington, D. C., to collaborate in research on the brain operation known as prefrontal lobotomy, according to the Honolulu *Advertiser*, March 2.

GENERAL

Vitamin B Complex Award Goes to Dr. Hogan.—Albert G. Hogan, Ph.D., professor of animal nutrition and chairman of the department of agricultural chemistry, University of Missouri, Columbia, has been given the vitamin B complex award for 1944, presented by Mead Johnson & Company through the American Institute of Nutrition. The award went to Dr. Hogan in recognition of his pioneer work on certain aspects of the vitamin B complex. According to the citation, this work has progressed successfully for many years and has contributed materially to the modern knowledge of vitamin B.

Work on Enzymes Receives Lilly Award.—Joseph Stewart Fruton, Ph.D., of the Rockefeller Institute of Medical Research, New York, was presented with the Eli Lilly and Company Prize of $1,000 for 1944 at the annual meeting of the American Chemical Society in Cleveland, April 5, in recognition of his "fundamental studies on the isolation, purification, mode of action and specificity of proteolytic enzymes of both plant and animal origin. The use of synthetic peptides as a tool in studying the specificity of enzymes was developed to a high degree and has afforded a new insight into the role of enzymes in the hydrolysis and synthesis of proteins."

Electron Microscope Used in Development of Penicillin.—The electron microscope is now being employed in advanced development of processes to help in the mass production of penicillin. Work is being pushed by chemists and bacteriologists in the research laboratories of Schenley Distillers Corporation, Lawrenceburg, Ind., whose converted whisky distilling facilities have been devoted exclusively to producing industrial alcohol for smokeless gunpowder, synthetic rubber and other priority products. The instrument is expected to be of value in extending investigations of fermentation of war alcohol and studies of yeast, according to an announcement.

Laboratory Animals and Medical Research.—The Universities' Federation for Animal Welfare announces preparation of a book dealing with the care and handling of laboratory animals to be used in connection with medical research. Dr. Frances Jean Vinter, secretary of the federation, has asked THE JOURNAL to notify American research scientists to communicate with the federation, giving any information which they would like to see incorporated in such a book with respect to anesthesia, euthanasia, training and supervision of assistants in the animal department, sources of supply other than breeding, handling and taming and means of providing exercise for animals to keep them in good condition. Communications can be addressed direct to Dr. Vinter at the office of the federation, 284 Regent's Park Road, Finchley, London, N. 3.

Association for Thoracic Surgery.—The twenty-fifth annual meeting of the American Association for Thoracic Surgery will be held at the Drake Hotel, Chicago, May 5-6, under the presidency of Dr. Edward D. Churchill, Boston. Among the speakers on the program will be:

Col. Burr Noland Carter and Major Michael E. DeBakey, M. C., Current Observations on Thoracic Surgery in the Present War.
Major Brian B. Blades and Capt. David J. Dugan, M. C., War Wounds of the Chest Observed at the Thoracic Surgery Center.
Drs. Paul H. Holinger and Ralph G. Rigby, Bronchoscopic Cinematography of Bronchial Tumors.
Dr. Alfred Blalock, Baltimore, Resection of the Thymus for Myasthenia Gravis.
Dr. Jerome R. Head, Chicago, An Evaluation of Monaldi Suction Drainage in the Treatment of Tuberculous Pulmonary Cavities.
Dr. Herbert C. Maier, New York, Lobectomy in Pulmonary Tuberculosis.

Meeting of Industrial Physicians and Surgeons.—The fourth annual convention of the Western Association of Industrial Physicians and Surgeons will be held at the Biltmore Hotel, Los Angeles, May 6, under the presidency of Dr. Calvin A. Walker, San Francisco. Included among the speakers will be:

Dr. Rodney R. Beard, San Francisco, Medicine as Related to Aviation.
Douglass A. Campbell, Los Angeles, Why Not Complete the Job?
Dr. Wilbur Bailey, Los Angeles, The More Frequent Errors in Reading X-Ray Films.
Dr. Marion J. Dakin, Los Angeles, Eliminating Psychogenic Factors in the Management of Physical Problems of Women Workers.
Dr. Dudley A. Irwin, Pittsburgh, Industrial Dusts, Including the Prevention and Treatment of Silicosis by Aluminum.
Dr. Alice Hamilton, Washington, D. C., Toxicity of the Industrial Solvents.
Capt. Henry H. Kessler (MC), Orthopedic Rehabilitation of the Injured.
Dr. Max R. Burnell, Flint, Mich., Women in Industry.

Meetings on Tuberculosis.—The National Tuberculosis Association, the American Trudeau Society, the National Conference of Tuberculosis Secretaries, the Mississippi Valley Conference on Tuberculosis and the Southern Tuberculosis Conference will hold their annual meetings at the Stevens Hotel, Chicago, May 9-12. Speakers appearing on the joint program will include:

Drs. Charles Eugene Woodruff, Northville, Mich., and William L. Brosius, Detroit, Tubercle Bacilli in Sputum and Tissues as Related to the Allergic State of the Patient.
Dr. Herbert C. Maier, New York, Surgical Treatment of Tension Cavities in Pulmonary Tuberculosis.
Drs. Leo G. Rigler and George K. Higgins, Minneapolis, Roentgen Observations on Chronic Cor Pulmonale.
Drs. George W. Wright, Trudeau, N. Y., and William Warriner Woodruff, Saranac Lake, N. Y., Effect of Surgical Collapse Therapy on Pulmonary Function.
Herman E. Hilleboe, senior surgeon, U. S. Public Health Service, Mass X-Rays in the Control of Tuberculosis in the Civilian Population.

Association for Research in Ophthalmology.—The fourteenth annual meeting of the Association for Research in Ophthalmology will be held at the Hotel Sherman, Chicago, June 13. The speakers will include:

Dr. Kenneth C. Swan and Norman G. White, M.S., Iowa City, Iowa, Choline Esters with Mydriatic and Cycloplegic Action.
Dr. Hermann M. Burian and George Wald, Ph.D., Boston, The Dissociation of Form and Light Perception in Amblyopia ex Anopsia.
Louise L. Sloan, Ph.D., Randolph Field, Texas, A Quantitative Test for Measuring Degree of Red-Green Color Deficiency.
Drs. Isabella H. Perry, Dr. Charles Weiss and Marion C. Shevky, A. B., San Francisco, A Study of the Pathogenicity of Diphtheroid Bacilli Isolated from the Human Conjunctiva.
Dr. Charles W. Ascher, Cincinnati, Backflow Phenomena in Aqueous Veins of Normal and of Glaucomatous Eyes.
George K. Smelser, Ph.D., and V. Ozanics, New York, Effect of Chemotherapeutic Agents on Cell Division of the Intact and Regenerating Corneal Epithelium Following Burns and Abrasions in the Rat.
Major John G. Bellows, M. C., Evaluation of the Use of Penicillin in Military Ophthalmology.

Medical Bills in Congress.—*Change in Status.*—H. R. 4624 has been reported to the House of Representatives with the recommendation that it pass, a bill to consolidate and revise the laws relating to the Public Health Service. *Bills Introduced.*—S. 1851, introduced by Senator Thomas, Utah, and H. R. 4615, introduced by Representative Bulwinkle, North Carolina, are companion bills to establish a division of tuberculosis control in the United States Public Health Service. This legislation proposes an appropriation of $10,000,000 for

the fiscal year ending June 30, 1945, and for each fiscal year thereafter a sum sufficient to carry out its purposes. The Surgeon General of the Public Health Service, with the approval of the Federal Security Administrator, will determine the total sum from the appropriations which will be available for allotment among the several states. S. 1858, introduced, by request, by Senator Clark, Missouri, proposes to give honorably discharged, disabled or retired marine employees of the Panama Canal civil service preference and to extend to them the facilities of the United States Public Health Service.

Association of American Physicians.—The fifty-eighth annual meeting of the Association of American Physicians will be held at the Claridge Hotel, Atlantic City, N. J., May 9, under the presidency of Dr. George Blumer, San Marino, Calif. Among the speakers will be:

Drs. George H. Whipple and Sidney C. Madden, Rochester, N. Y., Amino Acids and Plasma Protein Production.
Drs. James L. Gamble and Allan M. Butler, Boston, Measurement of the Renal Water Requirement.
Drs. Marion A. Blankenhorn and Eugene B. Ferris Jr., Cincinnati, On the Nature of Aviators' Bends.
Col. John T. King, M. C., Pulmonary Embolism and Infarction in Apparently Healthy Officers, with Applied Phlebography.

Various aspects of penicillin will be presented by Drs. Chester S. Keefer, Boston, Alfred N. Richards, Philadelphia, Francis G. Blake, Branch Craige Jr., Nicholas A. Tierney, New Haven, Conn., and Joseph E. Moore, Baltimore. In addition the program includes representatives of the government services.

Society News.—The Society for Investigative Dermatology will meet at the Stevens Hotel, Chicago, June 13. It is also announced that the *Journal of Investigative Dermatology*, which was suspended in 1943, will resume publication at an early date. Dr. Samuel William Becker, secretary of the society, reports that after May 1 his address will be 55 East Washington Street, Chicago.——The American Diabetes Association will hold its fourth annual meeting at the Hotel Sherman, Chicago, June 11. Dr. Cecil Striker, Cincinnati, is the secretary.——The Association of Surgeons of the Southern Railway System will hold its annual meeting in Winston-Salem, N. C., May 30-31.——The tremendous transportation problem has made it necessary for the Pennsylvania Railroad management to ask the Pennsylvania Railroad Surgeons Association not to hold a meeting this fall.——The sixteenth annual convention of the Aero Medical Association of the United States will be held at the Jefferson Hotel, St. Louis, September 4-6. Dr. David S. Brachman, 5440 Cass Avenue, Detroit 2, is the secretary.

College of Physicians.—Dr. David P. Barr, New York, was chosen president-elect of the American College of Physicians at its war session in Chicago, March 31-April 1, and Dr. Ernest E. Irons, Chicago, was installed as president. Other officers include Drs. Charles H. Cocke, Asheville, N. C., Walter W. Palmer, New York, and James J. Waring, Denver, vice presidents. Dr. George M. Piersol, Philadelphia, is the secretary-general and E. R. Loveland, Philadelphia, executive secretary. The following speakers appeared on the program:

Major Gen. David N. W. Grant, M. C., Aerial Transportation of the Sick and Wounded.
Brig. Gen. Hugh J. Morgan, M. C. (opening remarks).
Lieut. Col. Thomas Fitz-Hugh Jr., M. C., Experiences in India.
Col. Alexander Marble, M. C., Recurrent Malaria in Soldiers Evacuated from Overseas.
Vice Admiral Ross T. McIntire, Surgeon General of the U. S. Navy, The Great Need for Internists in the Navy Medical Program.
Capt. Don S. Knowlton (MC), Medical Men in the Solomons.
Capt. Albert M. Snell (MC), Medical Lessons Learned from the Evacuation of Casualties.
Dr. Francis G. Blake, New Haven, Conn., Scrub Typhus in New Guinea.

Association on Mental Deficiency.—The sixty-eighth annual meeting of the American Association on Mental Deficiency will be held at the Hotel Bellevue-Stratford, Philadelphia, May 11-15, under the presidency of Dr. Charles Stanley Raymond, Wrentham, Mass. Among the speakers on the program will be:

Edgar A. Doll, Ph.D., Millington, N. J., Suitability of Mental Defectives for Military Service.
Dr. Robert H. Haskell, Northville, Mich., The American Movement in Mental Deficiency.
Dr. Fred O. Butler, Eldridge, Calif., A Quarter of a Century's Experience in Sterilization of Mental Defectives in California.
Theodora M. Abel, Ph.D., Thiells, N. Y., Responses of Negro and White Morons to the Thematic Apperception Test.
Wesley C. George, Ph.D., Chapel Hill, N. C., Some Anomalies of Development and Their Probable Relation to Mental Deficiency.
Dr. Clemens E. Benda, Wrentham, Mass., The Familial Imbecile.
Dr. Leslie J. Bone, Pennhurst, Pa., Incidence of Disease Among Mental Defectives.
Dr. Ruth E. Duffy, Elwyn, Pa., A Case of Adenoma Sebaceum.

At a luncheon Thursday noon Arthur H. Estabrook, Ph.D., Philadelphia, will discuss "Postwar Problems in Mental Deficiency." At the president's dinner Friday evening Dr. Raymond will give his address on "Retrospect and Prospect in Mental Deficiency."

Meeting on Psychoanalysis and Psychosomatic Medicine.—The forty-sixth annual meeting of the American Psychoanalytic Association will be held at the Bellevue-Stratford Hotel, Philadelphia, May 13-15, under the presidency of Dr. Leo H. Bartemeier, Detroit. Among the speakers will be Dr. Harry Stack Sullivan, Washington, D. C., on "Notes on Theory and Practice from Twenty-Five Clinical Years." Lieut. Col. William C. Menninger, M. C., will be the guest speaker at the annual dinner Monday evening and Dr. Ernest Jones, London, England, president of the International Psycho-Analytical Association, the guest of honor. On May 15 a joint meeting of the American Society for Research in Psychosomatic Problems will be held with the American Psychiatric Association with the following speakers: George St. John Perrott, principal statistician, U. S. Public Health Service, on "The Prevalence of Chronic Disease," Col. Leonard G. Rowntree, M. C., "Psychosomatic Disorders as Revealed by the Examination of 13 Million Registrants" and Drs. Helen Flanders Dunbar and Jacob A. Arlow, New York, "Criteria for Therapy in Psychosomatic Disorders." The meeting will also include a panel discussion by Major Gen. George B. Chisholm and Lieut. Col. John D. M. Griffin, R. C. A. M. C., Colonel Menninger and Charlotte Carr, Washington, assistant to the vice chairman, War Manpower Commission.

Million Dollars for Teaching and Research in Physical Medicine.—On April 26 the sum of $1,100,000 was given by Bernard M. Baruch to be used for the teaching of and research into physical medicine. The money will be expended as follows:

The Columbia University College of Physicians and Surgeons, New York, $400,000 for the establishment of a key center of research and teaching of physical medicine, with particular reference to its application for returning veterans. This sum is to be expended over a ten year period. This center is to give immediate assistance in maintaining an adequate supply of medical specialists to handle the problems of war and postwar physical rehabilitation.

To New York University College of Medicine, $250,000 to be spent in ten years in establishing a center for teaching and special research in preventive and manipulative structural mechanics of physical medicine.

To Medical College of Virginia, Richmond (where the late Dr. Simon Baruch, father of Bernard Baruch, graduated in 1862), $250,000 to be expended in ten years in establishing a center for teaching and research with particular reference to hydrology, climatology and spa therapy.

To selected medical schools, $100,000 to develop an immediate program for the physical rehabilitation of war casualties and those injured in industry.

For the establishment of fellowships or residencies, $100,000 to be used for the benefit of qualified physicians who are selected to be trained in this field.

The gift was announced after a survey had been completed by the Baruch Committee on Physical Medicine, which was formulated to study the field of physical medicine and determine its potentialities. In making the gift Mr. Baruch, under the guidance of the committee, asked that each of the centers provide itself with an adequate team of workers among whom will be a specialist in clinical physical medicine and an appropriately trained and interested laboratory scientist. It is expected that this team will coordinate all work of the centers and gather others in the institution so that an effective group will be developed. With the Baruch donations and the preparation of its final report, which will soon be available, the committee ceases to function. A scientific advisory committee is being formed and offices have been established at 597 Madison Avenue, New York, under the chairmanship of Dr. Frank Krusen, head of the section on physical medicine, Mayo Clinic, Rochester, Minn., and professor of physical medicine, University of Minnesota Graduate School, Minneapolis-Rochester. Miss Grace Keefe will be in immediate charge as executive secretary. Dr. Ray Lyman Wilbur, chancellor of Stanford University, will be chairman of an administrative committee composed of Dr. Krusen and Miss Mary A. Boyle, a long time associate of Mr. Baruch. The actual survey into the field of physical medicine was begun Nov. 1, 1943 and was completed by February 1. The cost of the preliminary work has been defrayed by Mr. Baruch. Results of the committee disclosed three primary needs for the proper development of physical medicine:

An adequate supply of physicians who could teach physical medicine.
More basic research in physical medicine, including establishment of centers to promote carefully checked scientific research on commonly accepted nonmedical procedures, including those for which claims have been made by practitioners of osteopathy, chiropractic and such.
Proper usage of physical medicine in relation to wartime rehabilitation.

Mr. Baruch's interest in the field of physical medicine stemmed from the interest of his father, who had been professor of hydrotherapy at Columbia University College of Physicians and Surgeons.

Foreign Letters

LONDON

(From Our Regular Correspondent)

March 25, 1944.

The National Health Service

The White Paper declaring the intention of the government to establish a comprehensive national health service has at last come before Parliament. In the House of Lords the minister of reconstruction, Lord Woolton, moved a resolution welcoming this intention. He said that if the outline of the government's policy obtained the general approval of Parliament the ministers would enter into consultation with local authorities, voluntary hospitals and the several branches of the medical profession in order to arrive at agreement and hammer out the legislative details. Lord Moran, president of the Royal College of Physicians, moved an amendment to add to the motion the words "but regrets the absence of detail on many important matters, in particular on the consultant service." They could all commend the purpose of the White Paper, Lord Moran said; the aims had been advocated for many years by the profession itself, but what mattered was the means taken to achieve them. When discussions were opened with the minister of health, he recalled, members of the committee representing the profession asked that the Central Council be made a statutory body. That was conceded. But two more important assurances were asked for: that the council should be allowed to publish its own proceedings and that it should be elected by the profession and not nominated by the minister. The representatives were under the impression that the safeguards were conceded, but they did not appear in the White Paper. At the meetings, Lord Moran said, he was impressed by the general desire of all sections of the profession to find some alternative to the Ministry of Health to guide their destinies. This was not a healthy sign, he felt. The powers of the Central Medical Board to direct entrants to the profession were unusual. This would be called conscription in peacetime. Another result, he predicted, would be that the great majority of the profession would be removed from a life where the rewards were largely conditioned by success in practice into a service where the reward would have little relation to their success; thus there would be little incentive to competence. The changes foreshadowed seemed to Lord Moran to strike at the general practitioner as an individual.

Lord Dawson, president of the British Medical Association, said that some of the proposals in the White Paper gave him pleasure; others gave him concern. The scheme tried to go too far, Lord Dawson felt. The sensible thing would have been to take the foundations first and leave the superstructure for later, to be built in the light of experience. Why the enthusiasm, he asked, to push the health center for the purpose of group practice? It was a way, he thought, of insidiously introducing the principle of whole time salaried service. The only way the government could possibly administer a large profession was to put at the right hand of every administrative body a vocational body to advise and guide its policy. Once the profession came under the control of the civil service, would it be "goodbye to the best that medicine could do?" In the White Paper there cropped up too often what had been described as "the new despotism." The minister had powers to override everything. Lord Dawson emphasized the supreme necessity of private practice. The profession wanted the comprehensive service it had always advocated, he concluded, but it also wanted to preserve its great traditions and hand down its freedom to the generations to come.

In the House of Commons the minister of health, Mr. Willink, said that the national health service was one of the main pillars on which our postwar structure should rest and that it represented the biggest advance ever made in this country in the sphere of public health. There were four main principles, Mr. Willink said. The first was comprehensiveness: the service must be available to all, starting with the family doctor and ranging through the clinic to the consultant and hospital services. The second principle was freedom. No one, patient or doctor, must be coerced into this service. The third was democratic responsibility. The fourth was professional and vocational guidance. The ultimate responsibility must be fully democratic, Mr. Willink said, but the service must benefit throughout by the best expert professional guidance. There would be no regimentation of the medical profession, he added.

Sir Ernest Graham-Little, dermatologist, said that over 90 per cent of the medical profession were against any lay control of it, and that it was impossible to work any scheme if those who operated it were intensely resentful of the conditions imposed on them. Two physicians who are members of the labor party approved of the scheme and challenged Graham-Little's claim to represent a large part of the profession. He replied that those opposed to his views amounted to less than 10 per cent of the profession. It may be added that these dissenters belong almost entirely to the labor or socialist party. So also the lay members of Parliament of the labor party strongly support the scheme and desire that the physicians who will work it should be whole time state employees. The members of other parties in the House of Commons, while welcoming the scheme, criticized details such as control of the voluntary hospitals.

The British Medical Association has sent to all members of the medical profession, whether members of the association or not, (1) a copy of the White Paper, (2) an analysis of the principles approved by the association and (3) a questionnaire prepared by an expert lay body, the British Institute of Public Opinion. The questionnaire is elaborate and includes thirty items covering all the issues which have been or can be raised. The following are examples: "Should the national health service be confined to 90 per cent of the public, excluding the 10 per cent of the upper income group?" "Should complete hospital and specialist services be available to every one in a general ward?" "The profession rejects any proposal for control of the service by local authorities as at present constituted. Do you consider that the White Paper observes or infringes this principle?" Meetings of the profession to discuss the White Paper are to be held. Doctors are asked to attend the meeting in their district before filling in the questionnaire.

Danger of Closure of Hospital Because of Domestic Help Shortage

One of the consequences of the war is the shortage of all kinds of labor. This is particularly felt in the domestic sphere, where helpers are often unobtainable. Hospitals have to carry on with depleted medical staffs, but now an acute difficulty has arisen in domestic work. The chairman of St. Mark's Hospital for Diseases of the Rectum has written to the *Times* that this hospital, the principal one for these diseases in the British Empire, with a worldwide reputation, is in grave danger of having to close its doors before the end of this month. The reason is shortage of domestic personnel. No hospital can continue without a cook. No cook will stay without kitchen assistants. Every effort has been made to obtain these. Appeals have been made to the Ministry of Labor and the Ministry of Health without result, so as a last resort this cry for help in the *Times* has been made.

Deaths

Roscoe Hamilton Beeson, Muncie, Ind.; University of Louisville (Ky.) School of Medicine, 1918; member of the Indiana State Medical Association; fellow of the American College of Physicians and governor from 1928 to 1933; specialist certified by the American Board of Internal Medicine; past president of the Muncie Academy of Medicine and the Eighth Councilor District Medical Society; served during World War I; on the staff of the Ball Memorial Hospital, where he died March 30, aged 53, of diabetes mellitus.

Henry Brodman ✠ New York; Cornell University Medical College, New York, 1901; on the staff of the Beth Israel Hospital; died recently, aged 67, of coronary thrombosis.

Lucius M. Elsinger, Scranton, Pa.; Jefferson Medical College of Philadelphia, 1909; member of the Medical Society of the State of Pennsylvania; formerly city bacteriologist, and police and fire surgeon; served as head of the medical branch of the civilian defense unit in the West Scranton area; for many years a member of the staff of Scranton State Hospital; consultant at St. Mary's Hospital; on the staff of the Mercy Hospital, where he died February 9, aged 58, of pneumonia.

Sigfred Engh, Jackson, Minn.; University of Minnesota Medical School, Minneapolis, 1914; member of the Minnesota State Medical Association; served in France during World War I; died recently, aged 57, of cerebral hemorrhage.

John D. Ferguson, Ava, Mo.; National University of Arts and Sciences Medical Department, St. Louis, 1913; served during World War I; formerly mayor of Ava; died January 30, aged 66, of heart disease.

Charles Carroll Fishburne, Darien, Ga.; Atlanta Medical College, 1914; member of the Medical Association of Georgia; served as a captain in the medical corps of the U. S. Army during World War I; died in Jacksonville, Fla., February 3, aged 58, of uremia.

Cornelius Aultman Frame, Le Roy, N. Y.; Jefferson Medical College of Philadelphia, 1889; died January 17, aged 82, of arteriosclerotic heart disease and aneurysm of the abdominal aorta.

Cary Dennie Frederick, Los Angeles; Meharry Medical College, Nashville, Tenn., 1905; died January 30, aged 64, of myocarditis and arteriosclerosis.

Charles S. Goar, Indianapolis; Central College of Physicians and Surgeons, Indianapolis, 1888; member of the Indiana State Medical Association; at one time state senator; died February 4, aged 78, of myocardial degeneration and asthma.

LIEUT. JEAN H. WOLFS (MC), U.S.N.R., 1915-1944

Karl Lowenthal, Fall River, Mass.; Albert-Ludwigs-Universität Medizinische Fakultät, Freiburg, Baden, Germany, 1915; member of the Massachusetts Medical Society; chief of laboratory, Union Hospital and the Newport (R. I.) Hospital; died in the New England Deaconess Hospital, Boston, January 15, aged 51, of cerebral thrombosis and hypertensive cardiovascular disease.

George B. McGraw, Pawtucket, R. I.; Albany Medical College, Albany, N. Y., 1894; member of the Rhode Island Medical Society; died February 4, aged 77, of cerebral hemorrhage and hypertensive cardiovascular disease.

Carl Deloss Meacham ✠ Greene, N. Y.; Syracuse University College of Medicine, 1910; coroner of Chenango County; member of the Greene Rotary Club; died February 16, aged 57, of coronary occlusion.

John Bernard Menkhaus, University City, Mo.; Beaumont Hospital Medical College, St. Louis, 1898; died in St. John's Hospital, St. Louis, January 1, aged 74, of arteriosclerosis.

Henry King Miller, Fairland, Okla.; Barnes Medical College, St. Louis, 1906; member of the Oklahoma State Medical Association; died in the Miami Baptist Hospital, Miami, February 1, aged 67, of coronary occlusion.

Asa White Nickell ✠ Louisville, Ky.; Kentucky School of Medicine, Louisville, 1896; formerly associate professor of anatomy and gynecology at his alma mater; on the staff of SS Mary and Elizabeth Hospital; died February 15, aged 71, of coronary occlusion.

Patrick Henry O'Malley, Madison, Wis.; Rush Medical College, Chicago, 1901; died in a local hospital February 17, aged 71, of arteriosclerotic heart disease.

George Riddle Patrick, Bessemer City, N. C.; University of Maryland School of Medicine and College of Physicians and Surgeons, Baltimore, 1916; member of the Medical Society of the State of North Carolina; served during World War I; on the staff of the City Hospital, Gastonia, where he died February 5, aged 53, of coronary thrombosis.

Walter May Peck, Dallas, Texas; University of Michigan Department of Medicine and Surgery, Ann Arbor, 1903; formerly professor of medicine at Baylor University College of Medicine; died February 5, aged 66, of coronary disease.

James A. Pinkston, Independence, Kan.; Medico-Chirurgical College of Kansas City, Mo., 1902; member of the Kansas Medical Society; died January 25, aged 82, of diabetes mellitus.

Paul Joseph Piper, Pittsburgh; Georgetown University School of Medicine, Washington, D. C., 1939; on the staffs of the Veterans Administration facilities in Dearborn, Mich., and Aspinwall, Pa.; died in the Henry Ford Hospital, Detroit, February 21, aged 30, of liver abscess.

Charles Elbert Robb, Rock Island, Ill.; College of Physicians and Surgeons of Chicago, School of Medicine of the University of Illinois, 1906; member of the Illinois State Medical Society; past president and vice president of the Iowa and Illinois Central District Medical Society; past president of the Rock Island County Medical Society; served during World War I; a member and past president of the staff, St. Anthony Hospital; died February 27, aged 62, of coronary occlusion.

Joseph Franklin Roberts, Bolivar, Mo.; Missouri Medical College, St. Louis, 1877; member of the Missouri State Medical Association; past president and for many years secretary of the Polk County Medical Society, now known as the Dallas-Hickory-Polk County Medical Society, of which he was also past president; died in the Springfield Baptist Hospital, Springfield, February 10, aged 93.

Frederick Crosby Rumsey ✠ Kansas City, Mo.; University of Kansas School of Medicine, Kansas City, 1909; clinical assistant in medicine at his alma mater from Oct. 1, 1914 to September 1925; on the staffs of St. Luke's Hospital and St. Mary's Hospital, where he died February 1, aged 63, of pneumococcic pneumonia and coronary artery disease.

Isadore Sarnoff, Chicago; Jenner Medical College, Chicago, 1910; for many years physician and surgeon for the city police department; died in the Swedish Covenant Hospital February 26, aged 64, of injuries received when struck by an automobile.

Charles W. Tinker, Stewart, Minn.; Jefferson Medical College of Philadelphia, 1878; member of the Minnesota State Medical Association; died in the Vendome Hotel, Minneapolis, recently, aged 86, of angina pectoris.

Harry A. Walsh, Philadelphia; Jefferson Medical College of Philadelphia, 1921; member of the Medical Society of the State of Pennsylvania; died recently, aged 60.

KILLED IN ACTION

Jean Herold Wolfs, Glen Ridge, N. J.; University of Pennsylvania School of Medicine, Philadelphia, 1940; diplomate of the National Board of Medical Examiners; served an internship at the Kings County Hospital, Brooklyn; commissioned a lieutenant (jg), medical corps, U. S. Naval Reserve, in July 1942; served at Newport, R. I., and with amphibious forces at Little Creek, Va.; went overseas in March 1943 as medical officer on LCT; later promoted to lieutenant; died in action at Anzio-Nettuno beachhead, February 26, aged 28.

Correspondence

HISTORY OF MEDICINE

To the Editor:—In THE JOURNAL, March 18, appears an editorial entitled "Andreas Vesalius and Harvey Cushing: Tradition and Inspiration," from which I quote the following extract and which I believe, because the Association itself is approaching its centennial, is timely and worth repeating.

> Many of the greatest medical men have been historically minded. American activity in the history of medicine compares well with similar scholarship elsewhere. An enthusiastic group of physicians have supported it with both international and local studies, receiving loyal aid from capable bibliographers and collectors of medical literature. Nor should those publishers be forgotten who, time and time again, took risks in order to stand by the traditions which history and biography try to maintain.

The American Medical Association has no section devoted to medical history, as does the Canadian Medical Association and the British. When the American and Canadian associations held their joint session as I recall in 1937, because our Canadian associates had this cultural group, a special section was created for medical history at this meeting, and a resolution was sponsored recommending that the Board of Trustees of the American Medical Association create a section in our association for this purpose.

I believe that there is enough interest in this subject to support such a section. The field is broad and through lack of our initiative so much slight of hand medical history goes in the air over the radio, and through the lay press, that a more healthy view of the subject would result if trained physicians, not laymen, should weigh and evaluate the fine and valuable experience of the past with the ever changing trends of a living and continually advancing science.

I have no influence with the House of Delegates, but I hope that you will publish this letter, as I am sure there are others interested in your comments, and, further, that some movement may result toward the creation of such a section in the American Medical Association, and that the subject may be at least considered at the June meeting.

R. C. HOLCOMB, M.D., Upper Darby, Pa.

POSTURE DURING EXAMINATION OF RAPID HEART

To the Editor:—The clinical note "Posture During Examination of Rapid Heart," by Dr. L. S. Luton (THE JOURNAL, Nov. 13, 1943) suggests the following observations:

As the author states, the practice of having a patient take a deep inspiration and then bend forward at an angle of 90 degrees has been employed for some time as one of the many methods used in arresting paroxysmal tachycardia. Prior to my entry into the service I had occasion to examine a considerable number of applicants for employment in industries where exposure to nitrites was a hazard. It was essential to exclude individuals with very unstable vasomotor systems from this type of work. When applicants with a very rapid heart rate were encountered, this posture test was used in an attempt to slow the rate and facilitate examination.

It was observed that the test worked very well for persons of the vagotonic type who also showed wide fluctuations in systolic pressure as well as heart rate. These patients were usually of the intellectual type, and questioning often elicited neurotic tendencies. The unstable vasomotor systems of this group naturally made them poor candidates for this type of employment and they were excluded. On the other hand, a large group were encountered on which this test had no effect on slowing the rate. Rates up to 150 were frequently found. They were usually of the robust nonintellectual type and were simply scared to death of the doctor's office. They exhibited no other signs of vasomotor instability and usually quieted down after reassurance. In spite of their rapid rate, these persons were considered good candidates for employment.

JOHN T. LARKIN, Major, M. C., A. U. S.

Medical Examinations and Licensure

COMING EXAMINATIONS AND MEETINGS

NATIONAL BOARD OF MEDICAL EXAMINERS EXAMINING BOARDS IN SPECIALTIES

Examinations of the National Board of Medical Examiners and Examining Boards in Specialties were published in THE JOURNAL, April 22, page 1220.

BOARDS OF MEDICAL EXAMINERS

ALABAMA: Montgomery, Oct. 24-26. Sec., Dr. B. F. Austin, 519 Dexter Ave., Montgomery.

ALASKA: Juneau, September 5. Sec., Dr. W. M. Whitehead, Box 561, Juneau.

ARKANSAS:* *Eclectic.* Little Rock, June 8. Sec., Dr. C. H. Young, 1415 Main St., Little Rock.

CALIFORNIA: San Francisco, June 27-29 Sec., Dr. Frederick N. Scatena, 1020 N St., Sacramento.

CONNECTICUT:* *Written.* New Haven, July 11-12. *Endorsement.* New Haven, July 25. Sec. to the Board, Dr. Creighton Barker, 258 Church St., New Haven. *Homeopathic.* Derby, July 11-12. Sec., Dr. J. H. Evans, 1488 Chapel St., New Haven.

DELAWARE: Dover, Oct. 10-12. Sec., Medical Council of Delaware, Dr. J. S. McDaniel, 229 S. State St., Dover.

FLORIDA:* Jacksonville, June 26-27. Sec., Dr. W. M. Rowlett, Box 786, Tampa.

HAWAII: Honolulu, July 10-13. Sec., Dr. J. A. Morgan, 55 Young Bldg., Honolulu.

IDAHO: Boise, July 11. Dir., Bureau of Occupational Licenses, Mrs. Lela D. Painter, 355 State Capitol Bldg., Boise.

INDIANA: Indianapolis, May 2-4. Sec., Board of Medical Registration and Examination, Dr. W. C. Moore, 301 State House, Indianapolis.

IOWA:* Iowa City, Sept. 25-27. Dir. Division of Licensure and Registration, Mr. H. W. Grefe, Capitol Bldg., Des Moines.

KANSAS: November. Sec., Board of Medical Registration and Examination, Dr. J. F. Hassig, 905 N. Seventh St., Kansas City.

KENTUCKY: Louisville, Sept. 11-12. Sec., State Board of Health, Dr. Philip E. Blackerby, 620 S. Third St., Louisville.

MARYLAND: *Medical.* Baltimore, June 13-16. Sec., Dr. John T. O'Mara, 1213 Cathedral St., Baltimore. *Homeopathic.* Baltimore, June 20-21. Sec., Dr. J. A. Evans, 612 W. 40th St., Baltimore.

MASSACHUSETTS: Boston, July 11-14. Sec., Board of Registration in Medicine, Dr. H. Q. Gallupe, 413 F State House, Boston.

MICHIGAN:* Ann Arbor, July. Sec., Board of Registration in Medicine, Dr. J. E. McIntyre, 100 W. Allegan St., Lansing.

MINNESOTA:* Minneapolis, April 18-20. Sec., Dr. J. F. DuBois, 230 Lowry Medical Arts Bldg., St. Paul.

MISSISSIPPI: Jackson, May 29-30. Asst. Sec., State Board of Health, Dr. R. N. Whitfield, Jackson.

MISSOURI: St. Louis, August. Sec., State Board of Health, Dr. James Stewart, State Capitol Bldg., Jefferson City.

NEVADA: Carson City, May 1. Sec., Dr. G. H. Ross, 215 N. Carson St., Carson City.

NEW JERSEY: Trenton, June 20-21. Sec., Dr. E. S. Hallinger, 28 W. State St., Trenton.

NEW YORK: Albany, Buffalo, New York City and Syracuse, June 26-29. Sec., Dr. R. R. Hannon, Education Bldg., Albany.

NORTH CAROLINA: Raleigh, September. Sec., Dr. W. D. James, Hamlet.

NORTH DAKOTA: Grand Forks, July 5-8. Sec., Dr. G. M. Williamson, 4½ S. Third St., Grand Forks.

OHIO: *Endorsement.* Columbus, July 4. Sec., Dr. H. M. Platter, 21 W. Broad St., Columbus.

OREGON:* Portland, July. Exec. Sec., Miss L. M. Conlee, 608 Failing Bldg., Portland.

SOUTH CAROLINA: Columbia, June 26-28. Sec., Dr. N. B. Heyward, 1329 Blandena St., Columbia.

VERMONT: Burlington, Sept. 12-14. Sec., Dr. F. J. Lawliss, Richford.

WEST VIRGINIA: Charleston, May 1-3. Commissioner, Public Health Council, Dr. John E. Offner, State Capitol, Charleston.

WISCONSIN:* Milwaukee, June 27-29. Sec., Dr. C. A. Dawson, Tremont Bldg., River Falls.

WYOMING: Cheyenne, June 5-6. Sec., Dr. M. C. Keith, Capitol Bldg., Cheyenne.

* Basic Science Certificate required.

BOARDS OF EXAMINERS IN THE BASIC SCIENCES

COLORADO: Denver, June 7-8. Sec., Dr. E. B. Starks, 1459 Ogden St., Denver.

FLORIDA: Gainesville, June 8. Sec., Dr. J. F. Conn, John B. Stetson University, DeLand.

IOWA: Des Moines, July 11. Dir., Division of Licensure and Registration. Mr. H. W. Grefe, Capitol Bldg., Des Moines.

MICHIGAN: Ann Arbor and Detroit, May 12-13. Sec., Miss Eloise LeBeau, 101 N. Walnut St., Lansing.

NEBRASKA: Omaha, May 2-3. Dir., Bureau of Examining Boards, Mr. Oscar F. Humble, 1009 State Capitol Bldg., Lincoln.

NEW MEXICO: Santa Fe, June 12. Sec., Miss Marian M. Rhea, State Capitol Bldg., Santa Fe.

OKLAHOMA: Oklahoma City, July 3. Sec., Dr. J. D. Osborn Jr., Frederick.

OREGON: Corvallis, July 8. Final date for filing application is June 21. Sec., Board of Higher Education, Mr. C. D. Byrne, Eugene.

RHODE ISLAND: Providence, May 17. Sec., Division of Examiners, Mr. Thomas B. Casey, 366 State Office Bldg., Providence.

SOUTH DAKOTA: Vermillion, June 4-5. Sec., Dr. G. M. Evans, Yankton.

TENNESSEE: Nashville and Memphis, June 23-24. Sec., Dr. O. W. Hyman, Memphis.

WISCONSIN: Milwaukee, June 3. Sec., Prof. R. N. Bauer, 152 W. Wisconsin Ave., Milwaukee.

Bureau of Legal Medicine and Legislation

MEDICOLEGAL ABSTRACTS

Medical Practice Acts: Unlicensed Practice of Medicine by Chiropractor.—A complaint was filed against Minnie Black, who was licensed to practice chiropractic only in New Jersey, charging that she violated "Section 45:9-22 of Title 45 of the Revised Statutes [the section of the medical practice act of New Jersey prohibiting the practice of medicine except by a person licensed to do so and providing a penalty for a violation of the prohibition] without first having obtained and filed a license for such practice issued by the State Board of Medical Examiners." She was convicted and instituted certiorari proceedings in the supreme court of New Jersey.

Obviously, said the supreme court, the statement of conduct constituting the alleged violation of the medical practice act on the part of the chiropractor was in some way omitted. However, no point was made of this in the trial court, and no point is made of it now, and we construe the complaint as charging that the chiropractor, in the language of the section, either commenced or continued the practice of medicine without first having obtained the required license.

The chiropractor argued that there was no evidence before the trial court to show that she had practiced medicine since the witnesses who testified to having consulted her with regard to ailments were not suffering from any such ailments and visited her merely for the purpose of obtaining evidence on which to institute suit. Be this as it may, said the court, the witnesses stated conditions for which they desired treatment and that treatment was accorded. This, in our opinion, clearly indicates that the chiropractor did in the particular cases practice medicine in the sense intended by the medical practice act.

The chiropractor next contended that the language of the section of the medical practice act defining the practice of medicine and prohibiting such practice except by a licensed person is so broad as necessarily to cover a mere casual suggestion by A to B that, for example, bicarbonate of soda is good for an acid condition of the stomach and that, even though the situation did not exist, still because it might conceivably exist, the whole act is vitiated. To this contention, said the court, we think there are two sufficient answers. The first is that as a matter of reasonable construction the whole act relates to the practice of medicine, normally for financial reward, and in no way to casual recommendations between relatives and friends; and the second is that, even giving the act the broad construction contended for, it is within the power of the legislature constitutionally to say even that such casual recommendations are unlawful.

The judgment of conviction was affirmed.—*Black v. MacMahon, Judge, 32 A. (2d) 716 (N. J., 1943).*

Society Proceedings

COMING MEETINGS

American Medical Association, Chicago, June 12-16. Dr. Olin West, 535 N. Dearborn St., Chicago 10, Secretary.

American Association for the Surgery of Trauma, Chicago, June 9-10. Dr. Gordon M. Morrison, 520 Commonwealth Ave., Boston, Secretary.

American Association for Thoracic Surgery, Chicago, May 5-6. Dr. Richard H. Meade Jr., Kennedy General Hospital, Memphis, 15, Tenn., Secretary.

American Association of Genito-Urinary Surgeons, Stockbridge, Mass., June 8-10. Dr. Charles C. Higgins, 2020 E. 93d St., Cleveland, Secretary.

American Association of Industrial Physicians and Surgeons, St. Louis, May 8-11. Dr. Edward C. Holmblad, 28 East Jackson Blvd., Chicago, Managing Director.

American Association of Plastic Surgeons, Philadelphia, May 25-27. Dr. Frederick A. Figi, 102 Second Ave., S.W., Rochester, Minn., Secretary.

American Association on Mental Deficiency, Philadelphia, May 11-15. Dr. Neil A. Dayton, Mansfield Training School, Mansfield Depot, Connecticut, Secretary.

American Broncho-Esophagological Association, New York, June 6. Dr. Paul H. Holinger, 700 N. Michigan Ave., Chicago, Secretary.

American College of Allergists, Chicago, June 10-11. Dr. Fred W. Wittich, 401 LaSalle Medical Bldg., Minneapolis 2, Secretary.

American College of Chest Physicians, Chicago, June 10-12. Dr. Paul H. Holinger, 500 N. Dearborn St., Chicago, Secretary.

American College of Radiology, Chicago, June 14. Mr. Mac F. Cahal, 540 N. Michigan Ave., Chicago, Secretary.

American Diabetes Association, Chicago, June 11. Dr. Cecil Striker, 630 Vine St., Cincinnati 2, Secretary.

American Federation for Clinical Research, Chicago, June 12-13. Dr. Thomas M. Durant, 3401 N. Broad St., Philadelphia 40, Secretary.

American Gastro-Enterological Association, Chicago, June 12-13. Dr. J. Arnold Bargen, 102 Second Ave. S.W., Rochester, Minn., Secretary.

American Laryngological Association, New York, June 7-8. Dr. Arthur W. Proetz, 3720 Washington Blvd., St. Louis, 8, Secretary.

American Laryngological, Rhinological and Otological Society, New York, June 9-10. Dr. C. Stewart Nash, 277 Alexander St., Rochester, N. Y., Secretary.

American Medical Women's Association, Chicago, June 10-11. Dr. Carroll L. Birch, 2045 Sedgwick St., Chicago, Secretary.

American Neurological Association, New York, May 19-20. Dr. Henry Alsop Riley, 117 E. 72d St., New York 21, Secretary.

American Ophthalmological Society, Hot Springs, Va., May 29-31. Dr. Walter S. Atkinson, 129 Clinton St., Watertown, N. Y., Secretary.

American Physicians' Art Association, Chicago, June 12-16. Dr. F. H. Redewill, 536 Flood Bldg., San Francisco, Secretary.

American Proctologic Society, Chicago, June 11-15. Dr. W. H. Daniel, 1930 Wilshire Blvd., Los Angeles 5, Secretary.

American Psychiatric Association, Philadelphia, May 15-18. Dr. Winfred Overholser, St. Elizabeth's Hospital, Washington, D. C., Secretary.

American Psychoanalytic Association, Philadelphia, May 13-15. Dr. Robert P. Knight, 3617 W. Sixth Ave., Topeka, Kansas, Secretary.

American Society for Clinical Investigation, Atlantic City, May 8. Dr. Wesley W. Spink, University Hospitals, Minneapolis, Secretary.

American Therapeutic Society, Chicago, June 10. Dr. Oscar B. Hunter, 1835 I St. N.W., Washington 6, D. C., Secretary.

Association for Research in Ophthalmology, Chicago, June 13. Dr. B. F. Payne, School of Aviation Medicine, Randolph Field, Texas, Secretary.

Association for the Study of Internal Secretions, Chicago, June 12-13. Dr. Henry H. Turner, 1200 N. Walker St., Oklahoma City, Secretary.

Association of American Physicians, Atlantic City, May 9. Dr. Joseph T. Wearn, Lakeside Hospital, Cleveland, Secretary.

California Medical Association, Los Angeles, May 7-8. Dr. George H. Kress, 450 Sutter Street, San Francisco 8, Secretary.

Connecticut State Medical Society, Bridgeport, May 2-4. Dr. Creighton Barker, 258 Church St., New Haven, Secretary.

Georgia, Medical Association of, Savannah, May 9-12. Dr. Edgar D. Shanks, 478 Peachtree St. N.E., Atlanta, Secretary.

Hawaii Territorial Medical Association, Honolulu, May 5-6. Dr. A. V. Molyneux, 1133 Punchbowl St., Honolulu, Secretary.

Illinois State Medical Society, Chicago, May 16-18. Dr. Harold M. Camp, 54 S. Main St., Monmouth, Secretary.

Kansas Medical Society, Topeka, May 10-11. Dr. F. R. Croson, 112 West Sixth Street, Topeka, Secretary.

Massachusetts Medical Society, Boston, May 23-24. Dr. Michael A. Tighe, 8 Fenway, Boston 15, Secretary.

Mississippi State Medical Association, Jackson, May 9-10. Dr. T. M. Dye, Box 295, Clarksdale, Secretary.

National Tuberculosis Association, Chicago, May 10-12. Dr. Charles J. Hatfield, 1790 Broadway, New York, Secretary.

Nebraska State Medical Association, Omaha, May 1-4. Dr. R. B. Adams, 416 Federal Securities Bldg., Lincoln, Secretary.

New Hampshire Medical Society, Manchester, May 16. Dr. C. R. Metcalf, 5 S. State St., Concord, Secretary.

New York, Medical Society of the State of, New York, May 8-11. Dr. Peter Irving, 292 Madison Ave., New York 17, Secretary.

North Carolina, Medical Society of the State of, Pinehurst, May 1-3. Dr. R. D. McMillan, P. O. Box 232, Red Springs, Secretary.

North Dakota State Medical Association, Fargo, May 7-9. Dr. L. W. Larson, 221 5th Street, Bismarck, Secretary.

Ohio State Medical Association, Columbus, May 2-4. Mr. Charles S. Nelson, 79 E. State St., Columbus, Executive Secretary.

Rhode Island Medical Society, Providence, May 24-25. Dr. William P. Buffum, 127 Waterman St., Providence 3, Secretary.

Society for Investigative Dermatology, Chicago, June 13. Dr. S. W. Becker, 55 E. Washington St., Chicago, Secretary.

Society of American Bacteriologists, New York, May 3-5. Dr. W. C. Frazier, 310 Agricultural Hall, University of Wisconsin, Madison, Wis., Secretary.

South Dakota State Medical Association, Huron, May 21-23. Dr. Roland G. Mayer, 22½ S. Main St., Aberdeen, Secretary.

Texas, State Medical Association of, Dallas, May 10-11. Dr. Holman Taylor, 1404 W. El Paso Street, Fort Worth, Secretary.

West Virginia Medical Association, Wheeling, May 15-16. Mr. Charles Lively, P. O. Box 1031, Charleston, Executive Secretary.

Wyoming State Medical Society, Casper, May 28. Dr. M. C. Keith, Capitol Building, Cheyenne, Secretary.

Current Medical Literature

AMERICAN

The Association library lends periodicals to members of the Association and to individual subscribers in continental United States and Canada for a period of three days. Three journals may be borrowed at a time. Periodicals are available from 1934 to date. Requests for issues of earlier date cannot be filled. Requests should be accompanied by stamps to cover postage (6 cents if one and 18 cents if three periodicals are requested). Periodicals published by the American Medical Association are not available for lending but can be supplied on purchase order. Reprints as a rule are the property of authors and can be obtained for permanent possession only from them.

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Diet and Teeth. K. A. Easlick.—p. 40.

Oral Surgery

*Penicillin in Treatment of Cellulitis of Mouth. W. E. Herrell and D. R. Nichols.—p. 1.
Use of Higher Than Usual Concentrations of Procaine Hydrochloride in Dentistry. S. A. Lovestedt.—p. 8.
Cysts Arising from Mucosa of Maxillary Sinus as Seen in Dental Roentgenogram. J. A. Millhon and H. A. Brown.—p. 12.
Cysts of Jaws Lined with Ciliated Columnar Epithelium. S. A. Lovestedt.—p. 16.
Cystic Odontoma: Report of Case. E. C. Stafne.—p. 23.
*Basal Metabolic Rates and Dental Caries. L. T. Austin.—p. 50.

Penicillin in Cellulitis of Mouth.—Herrell and Nichols used penicillin in the form either of the sodium salt or of the calcium salt in 6 cases of extensive cellulitis of the floor of the mouth. In 2 cases the cellulitis was complicated by bacteremia. The use of penicillin did not produce toxic reactions. The extensive cellulitis responded almost dramatically to the use of penicillin. If subsequent studies show that penicillin therapy will accomplish satisfactory results in such cases, it may be possible to avoid extensive and radical surgical procedures. The use of penicillin may shorten the period of convalescence and reduce the hazard of complications associated with cellulitis of the mouth.

Basal Metabolic Rates and Dental Caries.—Austin reports that during the physical examination at the Mayo Clinic of a group of nurses a dental examination with dental roentgenograms was included, as well as a determination of the basal metabolic rate. The incidence of caries was progressively greater as the basal metabolic rate decreased. These studies were repeated on several incoming classes of nurses, and the same tendency was discovered in all groups. The number of patients is still too small to permit definite conclusions; yet the evidence that a relationship does exist between these conditions is sufficient to justify further studies.

American Journal of Pathology, Ann Arbor, Mich.

20:1-216 (Jan.) 1944

Transplantable Osteogenic Sarcomas Induced in Rats by Feeding Radium. C. E. Dunlap, J. C. Aub, R. D. Evans and R. S. Harris.—p. 1.
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Experimental Thrombotic Bacterial (Streptococcus Viridans) Endocarditis: I. Its Production and Incidence in Rabbit. L. Loewe, P. Rosenblatt and M. Lederer.—p. 89.
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Experimental Studies in Cardiovascular Pathology: VIII. Late Vascular Reactions of Histamine Shock in Dogs. W. C. Hueper and C. T. Ichniowski.—p. 211.

Annals of Surgery, Philadelphia

119:161-288 (Feb.) 1944

Report of Management of Burns Using Occlusive Compression Dressing, with Sulfathiazole Emulsion. D. Ackman, J. W. Gerrie, J. E. Pritchard and E. S. Mills.—p. 161.
*Refrigeration Anesthesia in Surgery. V. Richards.—p. 178.
Regeneration of Pre- and Postganglionic Fibers Following Sympathectomy of Upper Extremity: Experimental Study. H. D. Kirgis and E. A. Ohler.—p. 201.
*Total Pancreatectomy for Hyperinsulinism Due to an Islet Cell Adenoma: Survival and Cure at Sixteen Months After Operation; Presentation of Metabolic Studies. J. T. Priestley, M. W. Comfort and J. Radcliffe Jr.—p. 211.
Total Gastrectomy, Splenectomy, Resection of Left Lobe of Liver, Omentumectomy and Colectomy on One Patient in One Operation. F. H. Lahey.—p. 222.
Experiment in Early Diagnosis of Gastric Carcinoma. F. B. St. John, P. C. Swenson and H. D. Harvey.—p. 225.
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Cystomyoma of Seminal Vesicle. A. Plaut and S. Standard.—p. 253.
Teratoma of Testicle: Metastasis to Epigastrium Treated by Bilateral Orchiectomy—Recovery. E. R. Saleeby.—p. 262.
Compound Fracture of Fingers. C. H. Smith.—p. 266.
Regional Enteritis Involving Meckel's Diverticulum: Perforation of Diverticulum and Fistula Formation. R. C. Horn Jr. and J. E. Rhoads.—p. 274.

Refrigeration Anesthesia in Surgery.—Richards reports 2 unusual experiences with refrigeration of limbs. In the first case refrigeration of a limb, the seat of an unsuccessfully removed arterial embolus, was not gratifying. Although cooling of the anoxic limb had retarded the metabolic needs of the tissues and prevented gross necrotic changes, it had not prevented gangrene, it caused the available collateral blood vessels to contract and it had retarded both the stimulus for and the rate of growth of new collateral channels. In the second case the limb was refrigerated and then allowed to return slowly to room temperature. The author is inclined to doubt that refrigeration anesthesia may be used successfully in lengthy reconstruction operations on normal limbs. This skepticism would apply equally to the débridement and preservation of traumatized extremities. Once a tourniquet is applied to a limb, even though the tissues distal to the tourniquet should be cooled, irreversible changes in the specialized nerve and muscular tissues are apt to occur unless the well established principles governing the use of a tourniquet are observed. Many of the advocated advantages of refrigeration seem untenable. Bacterial growth is retarded by refrigeration, but so also is the tissue response to inflammation, and on release of the cooling the inflammatory reaction may even be aggravated. In an injured extremity with an intact blood supply the application of a tourniquet is extremely hazardous, for it increases immeasurably the subsequent shock by adding to trauma the effects of tissue asphyxia. Care must still be exercised to avoid prolonged application of the tourniquet if the part is to be preserved, for, although gross necrosis and postmortem changes in the asphyxiated tissues will not occur, the highly specialized nerve and muscular tissues in the limb may be irreparably damaged by ischemic fibrosis. The same objection to refrigeration anesthesia may be voiced against its use in extensive reconstructive operations on an extremity. Similar objections obtain in the presence of vascular occlusion of an extremity. Refrigeration anesthesia has decided advantages in the control of shock, hemorrhage and infection if sacrifice of the limb has been decided on. This has been demonstrated in elderly, debilitated patients toxic from gangrene or infection in a limb.

Total Pancreatectomy for Islet Cell Adenoma.—Priestley and his associates report a case of hypoglycemia due to hyperinsulinism from a small adenoma of the islets of Langerhans in which a total one stage pancreatectomy was performed. A less radical procedure would have failed to cure the patient, a woman aged 49, since the adenoma was located in the head of the gland in intimate proximity to the duodenum. The authors believe that this is the first case of a total pancreatectomy for benign or malignant disease in which survival has extended beyond the immediate postoperative period. Total pancreatectomy was followed by a relatively mild degree of diabetes. Disturbance of carbohydrate digestion was not detected by the methods used, while digestion of protein and

fat was definitely diminished. From 35 to 70 per cent of ingested fat and 25 to 55 per cent of ingested nitrogen could be accounted for in the feces. A positive nitrogen balance occurred in spite of the large loss of nitrogen in the feces. Foodstuffs in the urine and feces accounted for 21 to 34 per cent of the calories ingested. The percentage of total fat in the stools as neutral fat varied from 54 to 69. The dried weight of the stools was greater than values obtained for healthy persons. The patient has remained in excellent health sixteen months after the operation. Evidence of deficiency of lipocaic has not developed.

Bulletin of Johns Hopkins Hospital, Baltimore

74:1-84 (Jan.) 1944

Peculiar Type of Adrenal Cortical Damage Associated with Acute Infections and Its Possible Relation to Circulatory Collapse. A. R. Rich.—p. 1.

*Sudden Death in Young Adults in Association with Fatty Liver. R. L. Graham.—p. 16.

*An Intradermal Test for Recognition of Hypersensitivity to Sulfonamide Drugs. W. B. Leftwich.—p. 26.

Influence of Monocytosis of Peripheral Blood Stream on Cellular Character of Acute Inflammation. J. B. Frerichs.—p. 49.

Influence of Certain Amino Acids on Histamine Reactions and Anaphylactic Reactions in Intestinal Strips of Guinea Pigs and in Intact Guinea Pigs. S. W. Landau and L. N. Gay.—p. 55.

Sudden Death and Fatty Liver in Young Adults.—Graham calls attention to a form of sudden death about which little is known. It occurs in relatively young adults in whom necropsy does not reveal a significant pathologic lesion except a large diffusely fatty liver. Almost invariably a history of chronic alcoholism is obtained, but the history supported by chemical analysis shows also that at the time of death the victim usually had not been drinking. Death usually results with extreme rapidity and with little or no warning. A total of 11 cases, all occurring within the past year, are reported. Five of these are given in some detail and form the basis of this paper. In these the sole pathologic lesion found post mortem was a diffusely fatty liver. Six similar cases are briefly reported. In each of these, however, some additional lesion was present at necropsy which might be regarded as the cause or a main contributing cause of death. The ages of the first 5 patients ranged from 27 to 40 years, the average being 34.2 years. None of the deaths occurred during the summer, which would rule out heat stroke. Four cases closely resembled coronary death, yet the most careful search showed no demonstrable heart lesion. The cases associated with convulsive seizures might conceivably be compared to another so-called liver death, namely eclampsia. What relation, if any, there might exist between the two is unknown. No known reason for the cause of death has been ascertained, but it is suggested that a vitamin deficient state, with or without hypoglycemia, might be responsible.

Intradermal Test for Hypersensitivity to Sulfonamides.—Leftwich says that there is much clinical evidence that hypersensitivity to the sulfonamides is a true allergic reaction similar to serum sickness. Most attempts to demonstrate sensitivity to the sulfonamides by means of skin tests have failed. The present investigation is a study of 76 patients seen at Johns Hopkins Hospital, 38 of whom were thought to be clinically hypersensitive to various sulfonamide drugs, and 38 of whom were not thought hypersensitive and served as controls. The author describes a method by which positive skin tests may be obtained in patients who have shown hypersensitive reactions to the sulfonamide drugs. The material used for the skin test consisted of serum obtained from patients who were receiving a sulfonamide therapeutically and contained a drug level of from 2 to 25 mg. per hundred cubic centimeters. This skin test is simple to perform and easily interpreted and was found reliable in the diagnosis of drug sensitivity in 28 out of 30 cases of drug reactions. It is hoped that the test may be useful both in the differential diagnosis of drug reactions and perhaps as a precautionary measure before starting sulfonamide therapy of patients who have previously received one of these compounds. The fact that positive skin tests may be so consistently obtained in sensitive persons is additional evidence that drug sensitivity is an allergic reaction. The sensitizing antigen may be a sulfonamide plasma protein combination which occurs in vivo in the circulating blood of patients during sulfonamide therapy, the sulfonamide perhaps acting as haptene. The failure of 2 patients in this series, who developed hepatitis, and 1 patient, who developed hemolytic anemia as a result of sulfonamide therapy, to show positive skin reactions for the homologous sulfonamide supports the belief that the latter reactions are due to direct toxic action of the sulfonamide rather than to hypersensitivity.

Hawaii Medical Journal, Honolulu

3:1-56 (Sept.-Oct.) 1943

Preventive Psychiatry in Relation to Territorial Hospital: Analysis of Etiologic Factors in 538 Admissions. Dec. 7, 1940-Dec. 6, 1942. R. D. Kepner.—p. 7.

Honolulu Emergency Poliomyelitis Hospital. S. M. Wishik.—p. 17.

Observations on Poliomyelitis in Honolulu and on Mainland. S. F. Stewart.—p. 21.

3:57-108 (Nov.-Dec.) 1943

Sexual Sterilization: Physician's Obligation to His Patient. H. E. Bowles.—p. 65.

Multilocular Pseudomucinous Cystadenoma of Pancreas: Report of Case Successfully Extirpated with Discussion of Its Surgical Treatment. S. Yamauchi.—p. 67.

Heart Disease in Hawaii: Review of 160 Consecutive Cardiac Cases Seen in General Medical Clinic in Honolulu. A. S. Hartwell and J. W. Lam.—p. 71.

Journal Industrial Hygiene & Toxicology, Baltimore

26:1-36 (Jan.) 1944

Study of Pneumonia in Shipbuilding Industry: Epidemiology and Management of 864 Cases Over One Year Period in Kaiser Richmond Shipyards. M. F. Collen, G. L. Dybdahl and G. F. O'Brien.—p. 1.

Toxicology of Dichloromethane (Methylene Chloride): I. Studies on Effects of Daily Inhalation. L. A. Heppel, P. A. Neal, T. L. Perrin, M. L. Orr and V. T. Porterfield.—p. 8.

Id.: II. Effect on Running Activity in Male Rat. L. A. Heppel and P. A. Neal.—p. 17.

Possible Toxicity of Lead Alloys: III. Experiments on Rat with Lead-Tin-Antimony Solder. K. Salomon and G. R. Cowgill.—p. 22.

Experimental Ammonia Gas Poisoning in Rabbits and Cats. E. M. Boyd, M. L. MacLachlan and W. F. Perry.—p. 29.

Unusual Case of Trinitrotoluene (TNT) Poisoning. W. D. McNally.—p. 35.

26:37-44 (Feb.) 1944

*Chronic Toxicity of Moderate Concentrations of Benzene and of Mixtures of Benzene and Its Homologues for Rats and Dogs. J. L. Svirbely, R. C. Dunn and W. F. von Oettingen.—p. 37.

Toxicity of Lead Chromate. G. C. Harrold, S. F. Meek, G. R. Collins and T. F. Markell.—p. 47.

Diabetes and Injury. W. A. Bishop.—p. 55.

Quantitative Determination of Cyanide in Air. D. Lester.—p. 61.

Filargraph: Recording Device to Facilitate Filar Micrometry. E. D. Palmes.—p. 64.

Toxicity of Benzene and of Mixtures of Benzene.—According to Svirbely and his associates the homologues of benzene, chiefly toluene and xylene, have a greater effect on the nervous system but are less injurious to the blood-forming organs than benzene. Recently several mixtures consisting essentially of benzene and toluene have been advocated as substitutes for toluene. It was claimed that with these mixtures the chronic toxicity of benzene was attenuated to such an extent that chronic benzene poisoning was not likely. To check the validity of these claims, an investigation of two such blends was undertaken. The solvents studied were obtained from the manufacturer and consisted of benzene and two commercial blends designated as solvent X and solvent Y. Solvent X was a mixture of about 60 per cent benzene, 30 per cent toluene and 4 per cent xylene, while solvent Y contained from 50 to 60 per cent benzene, 35 per cent toluene and 4 per cent xylene. Both of these mixtures also contained varying percentages of other hydrocarbons. The experiments were made on rats, dogs and monkeys. The benzene as well as the solvents were vaporized. The concentrations inside the chambers were checked at hourly intervals, and the drop rate was adjusted to maintain the concentration of 1,000 parts per million. The exposure period was limited to seven hours daily for five consecutive days a week for twenty-eight weeks. Animals exposed to benzene seemed to present the same blood picture as those exposed to solvents X and Y. The most characteristic features were a relative lymphopenia followed by leukocytosis and lymphocytosis. The differential count indicated changes in the neutrophils and lymphocytes only. No severe anemia was noted. No definite changes were found in the blood picture

of dogs, but the urine tests indicated absorption and elimination of benzene and toluene. The urinary sulfate and hippuric acid excretion in the dogs depended on the benzene and toluene content of the solvents. The spleens of many of the rats exposed showed some evidence of toxic effects—hemosiderosis, small lymphoid follicles and narrowing of the perifollicular collars of closely packed, pale cells. Minor differences in the degree of change were noted in the case of each solvent. Significant pathologic changes were not noted in dogs exposed to the solvents.

Maine Medical Association Journal, Portland

35:1-22 (Jan.) 1944

Social Obligation of Physician. E. E. Holt Jr.—p. 1.
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35:23-40 (Feb.) 1944

S 1161., E. W. Gehring.—p. 23.
Dietary Inadequacy in Rural Maine. H. E. Lawrence.—p. 26.
Prevention of Vitamin Deficiencies in Wartime. F. R. Stenzel.—p. 31.

Minnesota Medicine, St. Paul

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Use of Sulfonamides in Abdominal Surgery. C. E. Rea.—p. 99.
Use of Dicumarol in Surgery. N. W. Barker.—p. 102.
Use of Blood and Blood Substitutes in Surgery. M. G. Gillespie and J. E. Blumgren.—p. 106.
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Management of Compound Hand Injuries. R. F. Mueller.—p. 110.
Involvement of Heart in Tularemia: Report of 2 Cases. G. N. Aagaard.—p. 115.
Cesarean Sections: Ten Year Statistical and Comparative Study from Ancker Hospital. H. D. McGee.—p. 117.
Five Year Survey of Cesarean Sections in Ramsey County, Minn. A. Skinner.—p. 124.

New England Journal of Medicine, Boston

230:95-124 (Jan. 27) 1944

*Pathology, Clinical Manifestations and Treatment of Lesions of Intervertebral Disks. A. Oppenheimer.—p. 95.
Parenterally Administered Amino Acids as Source of Protein in Man. S. H. Bassett, R. R. Woods, F. W. Shull and S. C. Madden.—p. 106.
Syphilis. G. M. Crawford.—p. 109.

Lesions of Intervertebral Disks.—According to Oppenheimer, lesions of the intervertebral disks are about twice as common as is duodenal ulcer. This high incidence may be explained by the evolution of the human spine. The vertebral column of man does not differ essentially from that of many quadrupeds. This means that a system of bones and joints that was originally adapted to bear almost no vertical stress sustains in man the whole impact of the upright posture and locomotion. In some persons the vertebral bone is less resistant to strain than are the disks, but in a majority of adults the disk cartilages are the weakest parts of the spine. Wear and tear cause numerous minimal injuries. Cartilage undergoes degeneration with increase of fibrous tissue. The result is loss of turgor and volume of the disk. The same changes may be caused by a single severe injury and by diseases of the adjacent vertebral bodies. Rupture of disks is one of the injuries which may be followed by degeneration. Flattening of disks leads to narrowing of the corresponding intervertebral spaces, associated with displacement of articular processes, narrowing of the neural foramen and abnormal contact between vertebral bodies. The clinical manifestations depend on these secondary alterations rather than on the degree of disk thinning. Narrowing of the neural foramen may cause radicular neuritis. The predominance of symptoms experienced in radicular distribution in the periphery over symptoms felt in the spine itself is perhaps due to the fact that the disk, being devoid of nerves, does not hurt when diseased. The most sensitive parts in its neighborhood are the nerve roots and the apophysial joints. Arthritis of these joints develops in about 20 per cent of the cases of disk lesions and produces pain in the back with limitation of vertebral motion. In the majority of cases, however, the apophysial joints remain intact. This means that in most cases lesions of disks cause symptoms felt in the limbs without symptoms felt in the back or neck. The signs and symptoms of radicular neuralgia and neuritis are often indistinguishable from those of myalgia, peripheral arthritis, bursitis and pain referred from diseased viscera. Moreover, in the age group in which the incidence of disk lesions is highest, involvement of joints, bursas and viscera is also common. Treatment may be surgical or conservative. Surgical removal of a ruptured disk followed by spinal fusion does not always prevent symptoms from developing after several years. Conservative treatment yields satisfactory results in about 75 per cent of the cases.

Oklahoma State Medical Assn. Jour., Oklahoma City

37:1-46 (Jan.) 1944

Some Observations Relative to Surgery of Thyroid. H. M. McClure.—p. 1.
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37:47-92 (Feb.) 1944

Fractional X-Ray Treatment of Skin Cancer. M. O. Nelson.—p. 47.
Examination of Foodhandlers—Findings in City of McAlester, Okla. P. T. Powell and H. Lowens.—p. 50.
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Spontaneous Gastrocolic Fistula: Report of 2 Cases. P. E. Russo.—p. 55.
Hyperventilation Syndrome. R. C. Kirk.—p. 59.

Public Health Reports, Washington, D. C.

59:65-96 (Jan. 21) 1944

Illness from Cancer in the United States: IV. Illness from Cancer of Specific Sites Classed in Broad Groups. V. Illness from Cancer of Individual Specific Sites. H. F. Dorn.—p. 65.
Cultivation of Pasteurella Tularensis in Liquid Medium. E. A. Steinhaus, R. R. Parker and M. T. McKee.—p. 78.

59:97-136 (Jan. 28) 1944

Illness from Cancer in the United States: VI. Regional Differences in Illness from Cancer. H. F. Dorn.—p. 97.

Radiology, Syracuse, N. Y.

42:107-212 (Feb.) 1944

*Roentgen Therapy of Wilms Tumor. E. W. Rowe and M. D. Frazer.—p. 107.
Urinary Tract Changes with Benign Pelvic Tumors. G. W. Chamberlin and F. L. Payne.—p. 117.
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Spondylolisthesis: General Consideration, with Emphasis on Radiologic Aspects. A. C. Galluccio.—p. 143.
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Use of Basal Metabolic Rate in Management of Radiotherapy for Leukemia. E. M. Uhlmann and M. Goldner.—p. 165.
Inhalation Pneumonia from Nitric Fumes. M. R. Camiel and H. S. Berkan.—p. 175.
Peyronie's Disease, or Plastic Induration of Penis. A. Soiland.—p. 183.
Technic for Optic Foramen Roentgenography. B. S. Epstein and M. Kulick.—p. 186.

Roentgen Therapy of Wilms Tumor.—According to Rowe and Frazer Wilms tumor, adenomyosarcoma, or embryonal mixed tumor of the kidney, is the most common renal neoplasm occurring in infancy and childhood. The patient is usually a child averaging 3 to 5 years of age, fairly well nourished and in apparent good health. A mass is found in either flank. It is of varying size, smooth contour and firm consistency and moves on deep inspiration. As metastases from Wilms tumor are generally blood borne, care should be taken not to palpate the tumor more than is absolutely necessary. Complete radiographic and urologic examination of the urinary tract is indicated. Biopsy is to be condemned because of the danger of spreading this anaplastic growth. Diagnosis should be based on the clinical history, physical examination and roentgenographic study. The author presents the histories of 4 children between 3 and 8 years of age with renal tumors. One of the children was treated by surgery and postoperative irradiation and the other 3 by preoperative irradiation, surgery and postoperative irradiation. The first patient died within five months. The remaining 3 show respectively a survival of four years and nine months; two years, and seven months. Combined preoperative irradiation, surgery and postoperative irradiation offer the most satisfactory method of treatment in these cases.

Book Notices

Internal Medicine in General Practice. By Robert Pratt McCombs, Lieutenant, Medical Corps, United States Naval Reserve. Cloth. Price, $7. Pp. 694, with 114 illustrations. Philadelphia & London: W. B. Saunders Company, 1943.

The author has attempted to combine in a comparatively limited space a compendium of internal medicine with a certain amount of clinical physiology, especially as it applies to the constantly increasing number of clinical and laboratory tests which play such an important role in modern diagnosis. The book contains numerous illustrations, some of them in colors and all of high quality. This book should be most useful to the busy general practitioner. In the opinion of the reviewer it is the best compendium on internal medicine which has appeared in recent years. In the diagnosis of diseases the author departs from the usual procedure of merely mentioning the various laboratory tests; these diagnostic procedures are described and interpreted in simple language which can readily be understood by the average physician. The author apologizes for the absence of a bibliography. However, a brief list of references is so essential to the modern student that perhaps the author will relent in his next edition and add a short bibliography to each chapter.

Physical Biochemistry. By Henry B. Bull, Ph.D., Associate Professor of Physiological Chemistry, Medical School of Northwestern University, Chicago. Cloth. Price, $3.75. Pp. 347, with illustrations. New York: John Wiley & Sons, Inc., 1943.

Many of the important advances in biochemistry made in the last quarter of a century have resulted from the application of physicochemical methods to the study of biochemical problems. For the serious student and worker in this field, a thorough knowledge and understanding of modern physical chemistry is essential. This implies not only a knowledge of chemistry, including biochemistry, but also a working knowledge of mathematics and physics. Lacking such a preparation in the fundamentals of the science, the average student of biology or medicine may nevertheless gather much information of interest and value from books like this one by Bull. The author discusses many of the recent applications of physicochemical methods to the study of biologic problems, although in most cases the treatment is much too brief to permit a student with no previous experience in this field to gain a real understanding of it. As indicated by the author, the book must be supplemented by a "generous amount of outside reading" before the student can hope to get a real insight into the complex relationships between physical chemistry and biology. In spite of the fact that this book does not take the place of a more comprehensive treatment of this subject, it serves a useful purpose because it directs the attention of the student to this important and fruitful borderline between physical chemistry and the biologic sciences.

Baby Doctor. By Isaac A. Abt, M.D. Cloth. Price, $2.50. Pp. 310, with portrait. New York & London: Whittlesey House, McGraw-Hill Book Company, Inc., 1944.

In telling his own story Dr. Abt tells also about the rise of pediatrics, for he was a pioneer leader in the development of pediatric science and practice. Special attention is directed to the realism of his descriptions of medical practice in Chicago at about the turn of the century, particularly with respect to children's diseases. He describes intimately the gradual improvements then beginning in pediatric teaching and hospital facilities as well as in practice and nursing. Abt's autobiography gives a realistic insight into the wonderful advances in the medical care of children with which he has had so much to do. The book is a simple but pleasant record, with humorous touches and characteristic anecdotes of a great lifework by a kindly, modest, learned and able clinician.

Protección de la infancia en el Peru. Por Urbano Valenzuela Hernandez. Paper. Pp. 77. Lima, Peru, 1942.

In the first part this monograph deals with infantile mortality in Peru and factors which contribute to it, in the second part with what is done today and what is planned for the future control of it. The monograph is a publication to be remembered by the students of problems of public health in Latin America.

Medical Aspects of Aviation (Speed and Acceleration). By Capt. Ernst Jokl, M.D. Cloth. Price, 10s. 6d. Pp. 104, with 122 illustrations by E. Ullman, Art Editor "The Forum," Johannesburg. London: Sir Isaac Pitman & Sons, Ltd., 1943.

This booklet is devoted to the effects of speed and acceleration on aviators. It describes with the aid of many illustrations and diagrams the physiologic results of dive bombing, sharp turns and tight spirals. A few pages are devoted to crash injuries and the methods of preventing or ameliorating such injuries in minor crashes. Most, but not all, of the material has been discussed in the standard works on aviation medicine. This small publication will not take the place of larger textbooks, but it does present one aspect of the subject in an entertaining manner.

The book is written in a popular style. Most of the illustrations are appropriate, some entirely superfluous. Jokl does not refer to a similar publication of his entitled Aviation Medicine, Cape Town, Unie-Volkspers Beperk, 1942, 213 pages. The author is best known for his book on The Medical Aspect of Boxing, Pretoria, J. L. Van Schaik, Ltd., 1941.

A Textbook of Biochemistry for Students of Medicine and Science. By A. T. Cameron, M.A., D.Sc., F.I.C., Professor of Biochemistry, Faculty of Medicine, University of Manitoba, Winnipeg. Sixth edition. Cloth. Price, $4. Pp. 376, with 28 illustrations. New York: Macmillan Company, 1942.

The subject of biochemistry is advancing so rapidly that some chapters of practically all books are out of date by the time they are published. For this reason any new book which serves to give the reader an accurate picture of the major changes taking place in biochemistry is useful. In the present edition, which is the sixth since the book was first published, in 1928, a number of alterations have had to be made in practically every chapter. This is especially true of those sections dealing with vitamins, diet, intracellular respiration, intermediary metabolism, nucleic acids, creatine formation and viruses. Although the book is too brief to be used as a general textbook of biochemistry for medical students, it will be found useful by readers who are interested in reviewing the subject and in keeping abreast of the rapid changes in this important field. The paper used in this book, which was printed in Great Britain, is very poor and reflects the changes produced by the war in that country.

Language and Thought in Schizophrenia: Collected Papers Presented at the Meeting of the American Psychiatric Association, May 12, 1939, Chicago, Illinois and Brought up to Date. Edited by J. S. Kasanin, M.D., Director, Department of Psychiatry, Mount Zion Hospital, San Francisco. With a preface by Nolan D. C. Lewis, M.D., Professor of Psychiatry, Columbia University Medical School, New York. Cloth. Price, $2. Pp. 133. Berkeley & Los Angeles: University of California Press, 1944.

This little monograph represents a collection of original contributions to the subject of language and thought in schizophrenias as presented at a meeting of the American Psychiatric Association in Chicago, May 12, 1939. The book contains an introduction and comments on each paper presented by Dr. Jacob Kasanin and a preface by Dr. Nolan Lewis. The contributors are all well known investigators in the field and include Drs. Harry Stack Sullivan, Kurt Goldstein, Norman Cameron, John D. Benjamin, E. von Domarus and Andras Angyal and S. J. Beck, Ph.D. The book is intended for advanced students in psychobiology, particularly those who are especially interested in schizophrenia. As such it is highly recommended and is the first correlated and certainly the best contribution to the subject since the classic work of Storch, which was published more than twenty years ago.

El pulso venoso normal. Por Agustín Caeiro. Tesis de doctorado en medicina, Universidad nacional de Córdoba, Facultad de ciencias médicas, Instituto de fisiología. Paper. Pp. 148, with 57 illustrations. Buenos Aires: Sebastián de Amorrortu e Hijos, 1942.

In this study the author has certainly gone beyond what is usually read in a thesis for a degree of doctor in medicine. The author has made a systematic and thorough analysis of the subject and has added numerous personal observations. He carried out his work at the Institute of Physiology of Cordoba under the guidance of Dr. Orias, who, together with Dr. Braun Menendez, is the author of a treatise on heart diseases recently translated into English by the Oxford University Press.

Queries and Minor Notes

THE ANSWERS HERE PUBLISHED HAVE BEEN PREPARED BY COMPETENT AUTHORITIES. THEY DO NOT, HOWEVER, REPRESENT THE OPINIONS OF ANY OFFICIAL BODIES UNLESS SPECIFICALLY STATED IN THE REPLY. ANONYMOUS COMMUNICATIONS AND QUERIES ON POSTAL CARDS WILL NOT BE NOTICED. EVERY LETTER MUST CONTAIN THE WRITER'S NAME AND ADDRESS, BUT THESE WILL BE OMITTED ON REQUEST.

IMPOTENCE AND ADMINISTRATION OF ENDOCRINES

To the Editor:—When impotence is improved by glandular therapy, which will give the more intense or prolonged results, testosterone or the gonadotropic hormones? Of the two types of gonadotropic substances, which gives better results, the true anterior pituitary gonadotropic hormone or the "pituitary-like" substances? My questions are prompted by the following case: A man aged 40 came to me about a year ago complaining of impotence. Desire was normal, but erections were weak and occasionally absent. Intercourse was attempted about twice weekly. Various female partners gave the same results. Sexual rest, advice, and tonics gave no results. Thorough check-up, including over a period of time basal metabolism, urine analysis, blood counts, Wassermann tests and cystoscopy, revealed nothing abnormal. He had not masturbated in years, practiced withdrawal or used a condom. After all this, and because his penis and testes seemed smaller than average for his stature, I concluded that there was a neurosis, based probably on hypogenitalism. He did not have the characteristics of the Froelich syndrome. He agreed to a course of testosterone injections. These were given three times a week (10 mg. ampules). Results were almost perfect, and the patient was so pleased that we repeated the series (a box of 50 ampules) several times last year. The penis became larger and erections good. I am now in the Army, and the patient is being treated by another physician with equally good results from the injections, but now the financial factor is entering into the problem. His doctor writes me asking whether, dollar for dollar, the gonadotropic substances will do what the testosterone is now doing or better, and if a combination of the two would not be better regardless of cost. Testosterone is too expensive now.

Captain, M. C., A. U. S.

ANSWER.—Usually, treatment of impotence by endocrine material is highly unsatisfactory unless the impotence is incidental to hypofunction of the testicles. Most impotence appears to be psychogenic and not distinctly susceptible to endocrine therapy. Gonadotropic substances stimulate testicular function to a variable degree. It appears that chorionic gonadotropin is the most potent of the three types, judging by the response of the interstitial tissue and by the descent of cryptorchid testes. It is difficult to make such comparison with accuracy, because the biologic units for comparison are not interchangeable between chorionic, equine and genuinely pituitary gonadotropins.

If the patient involved in a given decision is essentially an example of adiposogenital dystrophy or of hypofunction of the genitalia without obesity, it may be preferable to use gonadotropic therapy in order to achieve development of testicles as well as of the other genitalia. If no response occurs, testosterone propionate by injection or methyltestosterone orally may be used as substitutions for the function of the interstitial cells. This will not stimulate testicular function but will stimulate the other genital developments and functions to a considerable extent. The latter type of therapy is especially successful in climacteric cases, and there are some aspects of the case cited in the inquiry suggesting the climacteric rather than inadequate development.

The relative cost of the two types of treatment would have to be decided by trials in a given patient. It should be pointed out, however, that it is probably not worth while economically or socially to attempt such vigorous stimulation of this individual as is implied by the promiscuity referred to. The goal of treatment of patients with the climacteric is preferably autonomic and psychologic comfort rather than restoration of potency.

UNILATERAL CEREBRAL LESION

To the Editor:—Several weeks following an apparent tonsillitis at which time sulfadiazine 3¾ gr. every four hours was administered for three days, with recovery, and immediately following a superficial abrasion of the right knee, a three year old girl was noticed to limp. I was consulted about two weeks later when the limp noticed by the mother did not improve and she also noticed a weakness in the right hand. The child ate exclusively with the left hand and a glass of water in the right hand would fall from the child's grasp. There has been some progression of symptoms over the past six weeks. The following physical findings are reported: a definite spastic hemiplegia on the right, a slight shortening of the Achilles tendon and absence of the right abdominal reflexes. The plantar reflex on the right was extensor. The eye grounds were entirely negative. Urinalysis was negative. Hemoglobin was 11.7 grams and the white blood count was 10,200. A flocculation test for syphilis was negative. X-rays of the head, chest, right hip and tuberculin test were negative. There have been no headaches as far as can be determined and the child plays and appears happy and to have no complaints.

M.D., Ill.

ANSWER.—The patient probably has a left sided cerebral lesion, according to the submitted facts. The cause of this lesion is either inflammatory or vascular. In all probability the pathologic condition is that of encephalomalacia (cerebral softening) due to an endarteritis and finally thrombosis or a perivascular lesion due to an encephalitis. The treatment is essentially symptomatic. If there is any evidence of cardiac involvement the patient should have considerable rest. Potassium iodide (saturated solution) in doses of five drops three times daily may be given.

POSSIBLE CAUSES OF CRYING SPELLS

To the Editor:—An apparently healthy locomotive engineer aged 58 states that three times in one week he has had uncontrollable crying spells. I treated him three months ago for lobar pneumonia, and after his complete recovery he resumed work. No such disturbances were experienced previous to the pneumonia. Twice during his recovery he reported crying spells, but after a short time they disappeared. Yesterday he felt one coming on and left the group of men he was with and hid away and "cried like a baby." Today he experienced the same thing and I am asking help in making a diagnosis and establishing treatment. Would this be of endocrine origin?

Elmer W. Clark, M.D., Norton, Mass.

ANSWER.—The crying spells that are described may be a manifestation either of a psychiatric disorder or of a neurologic disease. These periods of crying may be the result of emotional problems which have produced anxiety and tension, manifestations of a psychoneurosis. A complete psychiatric study should be done to determine what, if any, emotional factors are concerned in the production of these symptoms. Another psychiatric disorder which may begin with symptoms of this type is arteriosclerotic brain disease, in which the vascular changes in the cerebral cortex produce a loss of inhibitory control with a resultant emotional instability. Usually a careful examination of the sensorium in such cases demonstrates disturbance in memory and a change in other intellectual functions. At times the psychiatric condition known as involutional melancholia will begin with crying spells, and it may be precipitated following a severe somatic illness. In such cases there will be a profound change in the general mood in the direction of depression. Many fears appear, particularly related to somatic function.

There is a neurologic syndrome resulting from lesions in the thalamocerebral pathways resulting in a condition known as forced crying or even forced laughing. The patient will suddenly exhibit unmotivated crying or laughing, without a concomitant subjective feeling of this emotional expression. Endocrine disorders are not commonly of etiologic importance in the condition described. However, in early hyperthyroidism it may be that emotional instability will result in crying spells.

A complete neurologic and psychiatric examination is necessary before establishing the diagnosis, and the treatment will then depend on which condition is present.

WATERY DISCHARGE FROM NIPPLE

To the Editor:—A woman of 67 has for more than a year noted a watery discharge from the left nipple. There is no deformity of the nipple nor palpable lump within the breast or in the axilla. The left breast seems a little bigger than the right; the patient is right handed. There is no other evidence of endocrine disturbance nor history of endocrine therapy. What chance is there that the process back of this discharge is an innocent one? How strongly should one insist on a biopsy? I shall probably have had the biopsy done before the inquiry is answered, for it is my impression that "more than a year" is a long time.

Nelson Morris, M.D., Toledo, Ohio.

ANSWER.—A watery discharge from the nipple of the breast is usually due to an intraductal papilloma, which may be malignant. These papillary growths, if not malignant, are potentially so. There is usually no localized tumor to indicate the location of the papilloma, and there may be multiple intraductal papillomas scattered throughout the lobules of the breast tissue. The surgical indication is that of simple mastectomy and, if the lesion proves to be malignant and infiltrating through the ducts, it should be treated by radical mastectomy.

HERPES ZOSTER AND ABSORPTION OF BISMUTH

To the Editor:—A woman aged 35 with a large chest wall abscess was treated by an injection of 2 ounces of bismuth paste, with considerable improvement. Several months later a purplish pigmentation was noted involving the tongue, palate and gums. This is now gradually fading. Is it reasonable to assume that these are cause and effect? More recently she developed herpes zoster. Might this be in any way related to the bismuth which still remains within her body?

Emil Rothstein, M.D., Rockville, Ind.

ANSWER.—It is most probable that the purplish pigmentation of the tongue, palate and gums was the result of the deposition of bismuth sulfide following the general absorption of significant quantities of bismuth from the site of the injection. Deposits of such extensive character are often associated with stomatitis and gingivitis, the latter tending to subside before disappearance of the coloration. Herpes zoster might well be related to such a stomatitis or gingivitis but otherwise has no likely connection with the absorption of bismuth.

JOURNALS ABSTRACTED IN THE CURRENT MEDICAL LITERATURE DEPARTMENT, JANUARY-APRIL 1944

Titles have been listed or abstracts made of important articles in the following journals in the Current Literature Department of THE JOURNAL during the past four months. Any of the journals, except those starred, will be lent by THE JOURNAL to subscribers in continental United States and Canada and to members of the American Medical Association for a period not exceeding three days. Three journals may be borrowed at a time. No journals are available prior to 1933. Requests for periodicals should be addressed to the Library of the American Medical Association and should be accompanied by stamps to cover postage (6 cents if one and 18 cents if three periodicals are requested). Thus most of these journals are accessible to the general practitioner.

American Heart Journal. St. Louis.
American Journal of Clinical Pathology. Baltimore.
American Journal of Digestive Diseases. Fort Wayne, Ind.
*American Journal of Diseases of Children. A. M. A., Chicago.
American Journal of Hygiene. Baltimore.
American Journal of the Medical Sciences. Philadelphia.
American Journal of Obstetrics and Gynecology. St. Louis.
American Journal of Ophthalmology. Cincinnati.
American Journal of Orthodontics and Oral Surgery. St. Louis.
American Journal of Orthopsychiatry. New York.
American Journal of Pathology. Ann Arbor, Mich.
American Journal of Physiology. Baltimore.
American Journal of Psychiatry. New York.
American Journal of Public Health. New York.
American Journal of Roentgenol. and Radium Therapy. Springfield, Ill.
American Journal of Surgery. New York.
American Journal of Syphilis, Gonor. and Venereal Diseases. St. Louis.
American Journal of Tropical Medicine. Baltimore.
American Review of Soviet Medicine. New York.
American Review of Tuberculosis. New York.
Anesthesiology. New York.
Annals of Allergy. Minneapolis.
Annals of Internal Medicine. Lancaster, Pa.
Annals of Otology, Rhinology and Laryngology. St. Louis.
Annals of Surgery. Philadelphia.
Archiv für Kinderheilkunde. Stuttgart.
Archiv für klinische Chirurgie. Berlin.
*Archives of Dermatology and Syphilology. A. M. A., Chicago.
Archives of Disease in Childhood. London.
Archives de l'Institut Pasteur d'Algérie.
*Archives of Internal Medicine. A. M. A., Chicago.
*Archives of Neurology and Psychiatry. A. M. A., Chicago.
*Archives of Ophthalmology. A. M. A., Chicago.
*Archives of Otolaryngology. A. M. A., Chicago.
*Archives of Pathology. A. M. A., Chicago.
Archives of Physical Therapy. Chicago.
*Archives of Surgery. A. M. A., Chicago.
Archivos Americanos de Medicina. Buenos Aires.
Archivos argentinos de pediatria. Buenos Aires.
Archivos de Pediatría del Uruguay. Montevideo.
Arquivos de cirurgia clinica e experimental. São Paulo.
Australian Journal of Experimental Biology and Medical Science. Adelaide.
Beiträge zur klinischen Chirurgie. Berlin.
Brain. London
British Heart Journal. London.
British Journal of Children's Diseases. Dorking, England.
British Journal of Dermatology and Syphilis. London.
British Journal of Experimental Pathology. London.
British Journal of Ophthalmology. London.
British Journal of Radiology. London.
British Journal of Surgery. Bristol.
British Journal of Tuberculosis. London.
British Journal of Urology. London.
British Journal of Venereal Diseases. London.
British Medical Journal. London.
Bulletin of the Johns Hopkins Hospital. Baltimore.
Bulletin of the Los Angeles Neurological Society.
Bulletin of the New York Academy of Medicine. New York.
Bulletin of the U. S. Army Medical Department. Washington, D. C.
California and Western Medicine. San Francisco.
Canadian Journal of Public Health. Toronto.
Canadian Medical Association Journal. Montreal.
Cancer Research. Baltimore.
Connecticut State Medical Journal. Hartford.
Delaware State Medical Journal. Wilmington.
Der deutsche Militärarzt. Berlin.
Deutsche medizinische Wochenschrift. Leipzig.
Deutsche Zeitschrift für Chirurgie. Berlin.
Diseases of Chest. Chicago.
Edinburgh Medical Journal.
Endocrinology. Springfield, Ill.
Experimental Medicine and Surgery. Brooklyn.
Gaceta Médica de Mexico. Mexico, D. F.
Gastroenterology. Baltimore.
Hawaii Medical Journal. Honolulu.
Helvetica medica acta. Basel.
Illinois Medical Journal. Chicago.
Indian Medical Gazette. Calcutta.
Irish Journal of Medical Science. Dublin.
Journal of Allergy. St. Louis.
Journal of the Arkansas Medical Society. Fort Smith.
Journal of Aviation Medicine. St. Paul.
Journal of Bacteriology. Baltimore.
Journal of Bone and Joint Surgery. Boston.
Journal of Clinical Endocrinology. Springfield, Ill.
Journal of Clinical Investigation. Boston.
Journal of Experimental Medicine. New York.
Journal of the Florida Medical Association. Jacksonville.
Journal of Immunology. Baltimore.
Journal of the Indiana State Medical Association. Indianapolis.
Journal of Industrial Hygiene and Toxicology. Baltimore.
Journal of Infectious Diseases. Chicago.
Journal of International College of Surgeons. Chicago.
Journal of the Iowa State Medical Society. Des Moines.
Journal of the Kansas Medical Society. Topeka.
Journal of Laboratory and Clinical Medicine. St. Louis.
Journal-Lancet. Minneapolis.
Journal of the Maine Medical Association. Portland.
Journal of the Medical Association of the State of Alabama. Montgomery.
Journal of the Medical Association of Georgia. Atlanta.
Journal of the Medical Society of New Jersey. Trenton.
Journal of Mental Science. London.
Journal of the Michigan State Medical Society. Lansing.
Journal of the Missouri State Medical Association. St. Louis.
Journal of the Mount Sinai Hospital. New York.
Journal of the National Cancer Institute. Washington, D. C.
Journal of Nervous and Mental Disease. New York.
Journal of Neurology and Psychiatry. London.
Journal of Neuropathology and Experimental Neurology. Baltimore.
Journal of Neurophysiology. Springfield, Ill.
Journal of Nutrition. Philadelphia.
Journal of Obstetrics and Gynaecology of British Empire. Manchester
Journal of the Oklahoma State Medical Association. Oklahoma City.
Journal of Pathology and Bacteriology. Edinburgh.
Journal of Pediatrics. St. Louis.
Journal of Pharmacology and Experimental Therapeutics. Baltimore.
Journal of Physiology. Cambridge.
Journal of Royal Army Medical Corps. London.
Journal of Royal Naval Medical Service. London.
Journal of the South Carolina Medical Association. Florence.
Journal of the Tennessee State Medical Association. Nashville.
Journal of Thoracic Surgery. St. Louis.
Journal of Urology. Baltimore.
Kentucky Medical Journal. Bowling Green.
Klinische Wochenschrift. Berlin.
Lancet. London.
Laryngoscope. St. Louis.
Medical Annals of the District of Columbia. Washington.
Medical Journal of Australia. Sydney.
Medicina. Buenos Aires.
Medicina. Madrid.
Medicine. Baltimore.
Medizinische Klinik. Berlin.
Mental Hygiene. Albany, N. Y.
Military Surgeon. Washington, D. C.
Minnesota Medicine. St. Paul.
Münchener medizinische Wochenschrift. Munich.
Nebraska State Medical Journal. Lincoln.
New England Journal of Medicine. Boston.
New Orleans Medical and Surgical Journal.
New York State Journal of Medicine. New York.
North Carolina Medical Journal. Winston-Salem.
Northwest Medicine. Seattle.
Ohio State Medical Journal. Columbus.
Ophthalmologia Ibero Americana. Buenos Aires.

*Cannot be lent.

Pennsylvania Medical Journal. Harrisburg.
Physiological Reviews. Baltimore.
Praxis. Bern.
Prensa Médica Argentina. Buenos Aires.
Psychiatric Quarterly. Utica, N. Y.
Psychosomatic Medicine. Baltimore.
Public Health Reports. Washington, D. C.
Publicações Médicas. São Paulo.
Quarterly Journal of Medicine. Oxford.
Quarterly Journal of Studies on Alcohol. New Haven, Conn.
Radiology. Syracuse, N. Y.
Review of Gastroenterology. New York.
Revista Argentina de Cardiología. Buenos Aires.
Revista Argentina de Neurología y Psiquiatría. Rosario.
Rev. Argentino-norteamericana de ciencias médicas. Buenos Aires.
Revista de la Asociación Médica Argentina. Buenos Aires.
Revista Chilena de Pediatría. Santiago.
Revista clínica española. Madrid.
Revista médica de Chile. Santiago.
Revista Mexicana de Pediatría. Mexico, D. F.
Revista de Otorrinolaringología. Santiago.
Revista de la Sociedad de Pediatría de Rosario.
Revista de Tuberculosis. Havana.
Rhode Island Medical Journal. Providence.
Rocky Mountain Medical Journal. Denver.
Semana médica. Buenos Aires.
South African Medical Journal. Cape Town.
Southern Medical Journal. Birmingham, Ala.
Southwestern Medicine. Phoenix, Ariz.
Surgery, St. Louis.
Surgery, Gynecology and Obstetrics. Chicago.
Texas State Journal of Medicine. Fort Worth.
Transactions of the Royal Society of Tropical Medicine and Hygiene. London.
Tubercle. London.
Union Médicale du Canada. Montreal.
United States Naval Medical Bulletin. Washington, D. C.
Urologic & Cutaneous Review. St. Louis.
Virginia Medical Monthly. Richmond.
•War Medicine. A. M. A., Chicago.
Western Journal of Surgery, Obstetrics and Gynecology. Portland, Ore.
West Virginia Medical Journal. Charleston.
Wisconsin Medical Journal. Madison.
Yale Journal of Biology and Medicine. New Haven.
Zeitschrift für Immunitätsforschung. Jena.
Zentralblatt für Chirurgie. Liepzig.

SUBJECT INDEX

This is an index to all the reading matter in THE JOURNAL. In the Current Medical Literature Department only the articles which have been abstracted are indexed.

The letters used to explain in which department the matter indexed appears are as follows: "BI," Bureau of Investigation; "E," Editorial; "C," Correspondence; "OS," Organization Section; "ab," abstracts; the star (*) indicates an original article in THE JOURNAL.

This is a subject index and one should, therefore, look for the subject word, with the following exceptions: "Book Notices," "Deaths," "Medicolegal Abstracts" and "Societies" are indexed under these titles at the end of the letters "B," "D," "M," and "S." State board examinations are entered under the general heading State Board Reports, and not under the names of the individual states. Matter pertaining to the Association is indexed under "American Medical Association." The name of the author, in brackets, follows the subject entry.

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Acad.—Academy
Am.—American
A.—Association
Coll.—College
Conf.—Conference
Cong.—Congress
Conv.—Convention
Dist.—District
Hosp.—Hospital
Internat.—International
M.—Medical
Med.—Medicine
Nat.—National
Pharm.—Pharmaceutical
Phys.—Physician
Rev.—Revision
Ry.—Railway
Soc.—Society
Surg.—Surgery
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